

<i>SERFF Tracking Number:</i>	<i>HUMA-127883199</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Humana Dental Insurance Company</i>	<i>State Tracking Number:</i>	<i>50496</i>
<i>Company Tracking Number:</i>	<i>AR-11-009</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>AR App Maint - HDIC</i>		
<i>Project Name/Number:</i>	<i>Apps Update/PC-114</i>		

## Filing at a Glance

Company: Humana Dental Insurance Company

Product Name: AR App Maint - HDIC

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: HUMA-127883199 State: Arkansas

SERFF Status: Closed-Approved State Tr Num: 50496

Co Tr Num: AR-11-009

State Status: Approved-Closed

Reviewer(s): Donna Lambert

Author: Wendy Jeffries

Disposition Date: 12/20/2011

Date Submitted: 12/16/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 01/20/2012

State Filing Description:

## General Information

Project Name: Apps Update

Project Number: PC-114

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 12/20/2011

State Status Changed: 12/20/2011

Created By: Wendy Jeffries

Corresponding Filing Tracking Number:

Filing Description:

This is a new filing; the attached forms do not replace or supersede any like forms previously filed. These forms are for use in the group market. These forms are being filed for general use with all approved policy series and may be offered in a printed, online, or digitized audio recorded format.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: na

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Wendy Jeffries

This application will be used to support our currently marketed products in your state. The changes in the application reflect cosmetic changes in format, design and language. These changes are intended to create a more consumer friendly application form for our future applicants to assist them in understanding the application process.

Included with this submission are the following documents:

- Certificate of Readability; and
- Filing Fee of \$200 (\$50 per form).

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Product Name: AR App Maint - HDIC  
Project Name/Number: Apps Update/PC-114

To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Arkansas statutes and regulations.

If you have any questions regarding this filing, please contact me by phone at (800) 664-4140, extension 1783 or by e-mail at wjeffries@humana.com.

## Company and Contact

### Filing Contact Information

Wendy Jeffries, Regional Contract Analyst wjeffries@humana.com  
321 W. Main Street 502-580-1783 [Phone]  
6th Floor, East Tower  
Louisville, KY 40202

### Filing Company Information

Humana Dental Insurance Company	CoCode: 70580	State of Domicile: Wisconsin
1100 Employer's Blvd	Group Code: 119	Company Type:
Green Bay, WI 54344	Group Name:	State ID Number:
(800) 558-4444 ext. [Phone]	FEIN Number: 39-0714280	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$200.00
Retaliatory?	No
Fee Explanation:	4 forms x \$50 equals \$200.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Dental Insurance Company	\$200.00	12/16/2011	54594660

SERFF Tracking Number:	HUMA-127883199	State:	Arkansas
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/20/2011	12/20/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	12/20/2011	12/20/2011	Wendy Jeffries	12/20/2011	12/20/2011

<i>SERFF Tracking Number:</i>	<i>HUMA-127883199</i>	<i>State:</i>	<i>Arkansas</i>
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## Disposition

Disposition Date: 12/20/2011

Implementation Date: 01/20/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	Statement of Variability	Approved	Yes
<b>Form</b>	100+ Employer Group Application	Approved	Yes
<b>Form</b>	2-99 Employer Group Application	Approved	Yes
<b>Form</b>	Group Employee and Individual App and Enrollment form 2-99 Employees	Approved	Yes
<b>Form</b>	Large Group Employee and Individual App and Enrollment form	Approved	Yes

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Filing Company: Humana Dental Insurance Company State Tracking Number: 50496  
Company Tracking Number: AR-11-009  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: AR App Maint - HDIC  
Project Name/Number: Apps Update/PC-114

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 12/20/2011  
Submitted Date 12/20/2011  
Respond By Date 01/20/2012

Dear Wendy Jeffries,

This will acknowledge receipt of the captioned filing.

The Filing Description states that these forms do not replace any previously approved forms, then states, "The changes in the application reflect cosmetic changes in format, design and language." What language has been changed?

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/20/2011
Submitted Date	12/20/2011

Dear Donna Lambert,

### Comments:

### Response 1

Comments: The biggest alteration was that we have combined all of our lines of business into one form so we have taken elements from previous filed forms and added them to this single form for agent and group convenience.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,  
Wendy Jeffries

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 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
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## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
<b>Status</b>							
Approved 12/20/2011	AR-71012- EA-LG 20111114	Application/ Enrollment Form	100+ Employer Group Application	Initial			AR-71012- EA-LG- 20111114.pdf
Approved 12/20/2011	AR-71012- EA-SB 20111114	Application/ Enrollment Form	2-99 Employer Group Application	Initial			AR-71012- EA-SB- 20111114.pdf
Approved 12/20/2011	AR-72000 20111103	Application/ Enrollment Form	Group Employee and Individual App and Enrollment form 2-99 Employees	Initial			AR-72000- 20111114.pdf
Approved 12/20/2011	AR-72001 20111114	Application/ Enrollment Form	Large Group Employee and Individual App and Enrollment form	Initial			AR-72001- 20111114.pdf



# [100+] Employer/Group Application - Arkansas



FOR GROUP COVERAGE (100+ ELIGIBLE EMPLOYEES)

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group/Employer Application as "Humana".

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

<b>[1-10]. EMPLOYER COMPANY INFORMATION:</b> Please type or print clearly in black ink						<b>Internal use only</b> Group number:	
Full legal business name							Requested effective date __/__/____
Corporate/Situs location street address (P.O. Box not allowed)				City	State	ZIP code	County
Type of business	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Sole Proprietorship	Date company established		Federal Tax ID	
				<input type="checkbox"/> Church or Government entity		<input type="checkbox"/> Other (explain) _____	
Nature of business/SIC code			Business phone number ( )		Business fax number ( )		
Do you have more than one location? <input type="checkbox"/> No <input type="checkbox"/> Yes							
<b>Benefit Administrator/Management contact name:</b>							
Phone number ( )			Fax number ( )			E-mail	
Management contact: Mother's maiden name _____ (this will be used to gain access to the Employer Self-Service Center on www.Humana.com)							
<b>Billing contact name:</b>							
Billing address (N/A, if same as street address)					City	State	ZIP code
Phone number ( )			Fax number ( )			E-mail	
[Are separate divisions/classes required for billing or reporting? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.]							
<b>[For Workplace Voluntary Benefits:</b> Effective date of policy and due date of first premium will be (month, day, year) __/__/____]							
<b>[Type of Billing:</b> <input type="checkbox"/> Self Billed <input type="checkbox"/> Listed Billed <b>Premium mode:</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual]							

## [1-10]. ELIGIBILITY REQUIREMENTS

Number of employees on payroll \_\_\_\_\_. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	[All]	[Medical]	[Dental]	[Life]	[Vision]	[STD]	[LTD]	[Group Critical Illness]	[Workplace Voluntary Benefits]
A. Number of hours worked per week to be eligible (select between 20 and 40 hours)									
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)									
C. Total number of eligible employees									
Number of employees:									
• waiving with other qualifying coverage									
• waiving without other qualifying coverage									
Number of employees to be enrolled	]	]	]	]	]	]	]	]	]
Probationary waiting period for eligible employees: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other (specify) _____ (if you prefer months, please select "Other" and specify the number of months)									
Employee effective provision: [(On all plans, except STD and LTD, the employee termination date coincides with the effective date provision. STD/LTD is immediate.)]									
[New <input type="checkbox"/> First of month following probationary waiting period <input type="checkbox"/> Immediately following probationary waiting period]									
[Rehire <input type="checkbox"/> First of month following probationary waiting period <input type="checkbox"/> Immediately following probationary waiting period]									

**[1-10]. ELIGIBILITY REQUIREMENTS** (continued)Do you want to exclude a class of employees? ☐ No ☐ Yes

If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)

☐ union ☐ non-union ☐ hourly ☐ salary ☐ management ☐ non-management ☐ other: \_\_\_\_\_**Employee Eligibility by Class**

According to Federal health care reform, an employer's group health plan cannot discriminate in favor of highly-compensated employees. Doing so may result in a penalty. To avoid penalties, please review any class-based benefits with your legal or financial advisor to ensure your group health plan does not favor highly compensated employees. (Excludes grandfathered health plans).

Has this group been insured by Humana within the last three years? ☐ No ☐ Yes

If yes, please provide prior group number and termination date: \_\_\_\_\_

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of Plan \_\_\_\_\_  
Plan number \_\_\_\_\_ (Assigned by Employer for use in filing IRS form 5500)Do you wish to offer Domestic Partner Coverage? ☐ No ☐ Yes**Retiree information**For groups 26+, are you offering coverage to retirees? ☐ No ☐ Yes If yes, required age \_\_\_\_\_ Minimum years of service \_\_\_\_\_

	All	Medical	Dental	Vision	Life (if applicable)
Number of current retirees to be covered					

Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes If yes, enter information below:

Company name	Total employees

**[Group Term Life,] [Short Term Disability,] [Long Term Disability,] and [Group Critical Illness] only**

Effective dates for changes in amounts of coverage	Effective first day of month following change	Other
Increases/decreases due to change in class	<input type="checkbox"/>	
Increases/decreases requested by employee	<input type="checkbox"/>	
Increases (with Evidence of Insurability) requested by employee	<input type="checkbox"/>	
Decreases due to age	<input type="checkbox"/>	

Evidence of Insurability required if amount of coverage applied for exceeds amounts below:

	Class 1	Class 2		Class 1	Class 2
Employee life	\$	\$	Spouse life	\$	\$
Employee STD	\$	\$	Basic group critical illness	\$	\$
Employee LTD	\$	\$	Buy-up group critical illness		

☐ **Special requests:** Check box and attach signed additional sheet or letter, if custom dating, face amounts, etc. are desired.**[W-2 Services Option (Please choose one)]**☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this Application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established as standard procedures.]

**[1-10]. COBRA/STATE CONTINUATION**Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes

Number of existing COBRA participants	Medical:	Dental:	Vision:
How many in COBRA election period	Medical:	Dental:	Vision:

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes

If yes, enter information below. Attach additional signed and dated sheets (reorder AR-52247), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date

**[1-10]. EMPLOYER CONTRIBUTION(S)**

**[Medical only]:** Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes

If yes, indicate amount funded \$ \_\_\_\_\_ ]

**[STD and LTD only]:** Are employer contributions taxed in employee paychecks? ☐ No ☐ Yes

Coverage Employer's contribution for:	[Medical]	[Dental]	[Vision]	[Life]	[Voluntary Life]	[STD]	[BUY UP STD]	[LTD]	[BUY UP LTD]	[Workplace Voluntary Benefits]	[Spending Account*]
Employee	%	%	%	%	%	%	%	%	%	%	\$
Employee/spouse	%	%	%	%	%	N/A	N/A	N/A	N/A	%	\$
Employee/child	%	%	%	%	%	N/A	N/A	N/A	N/A	%	\$
Family	%]	%]	%]	%]	%]	N/A]	N/A]	N/A]	N/A]	%]	\$ ]

[\*For medical plans, Humana reserves the right to re-evaluate rates and require new premium prior to underwriting approval or issuing coverage with employer contributions greater than 50% of a plan's deductible to an employee's spending account.]

**[1-10]. PRIOR/CURRENT CARRIER INFORMATION**

	[Medical]	[Dental]	[Life]	[Vision]	[STD]	[LTD]
Is this group transferring from another group carrier?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, provide carrier name						
Proposed termination date	]	]	]	]	]	]
<b>[Dental only]:</b> Did prior dental coverage include orthodontia? <input type="checkbox"/> No <input type="checkbox"/> Yes						
<b>[For Workplace Voluntary Benefits - Existing coverage available to employees]</b>						
[Disability income carrier _____		<input type="checkbox"/> Individual	<input type="checkbox"/> Group	Coverage termination date _____ ]		
[CI/Cancer carrier _____		<input type="checkbox"/> Individual	<input type="checkbox"/> Group	Coverage termination date _____ ]]		

**[1-10]. PRODUCT SELECTION -** To complete this section, please refer to the Underwriting Requirements (reorder AR-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

**[a-g]. MEDICAL PLANS**

Is this a SmartSuite selection? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Product specification:	Product specification:				
Product specification:	Product specification:				
Product specification:	Product specification:				
<input type="checkbox"/> Health Care Flexible Spending Account (FSA) <input type="checkbox"/> Dependent Care Flexible Spending Account (FSD) <input type="checkbox"/> Health Savings Account (HSA) <input type="checkbox"/> Personal Care Account offered with product specification:					
Are there any disabled dependents over the age of 19 to be covered in this group? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, please provide on a separate sheet of paper (reorder GN-52422): name of employee, dependent name, statement of disability/diagnosis from attending physician, dependency statement from employee and the current group carrier insuring the dependent.					
To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period: (check all that apply)					
<ul style="list-style-type: none"> <li>confined at home, in a hospital, or a treatment facility <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>who incurred more than \$25,000 of medical expenses in the last 12 months <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>who has been advised within the last 90 days to have surgery or be hospitalized <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>who is eligible for and/or covered by Medicare related to a disability or End-Stage Renal Disease <input type="checkbox"/> No <input type="checkbox"/> Yes</li> </ul>					
For any checked option, please complete the information below. Attach additional signed and dated sheets (reorder GN-52338), if necessary.					
<b>Member Status*</b>	<b>Age</b>	<b>Medical Condition/Diagnosis</b>	<b>Date(s) of Treatment</b>	<b>Medication Name/Dosage</b>	<b>Past/Current/Future Treatment</b>

\* Member Status: E=Employee D=Dependent C=COBRA R=Retiree Class

**[Health Questionnaire for groups enrolling [100+] employees: (check all that apply)**

1. Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury? ☐ No ☐ Yes
2. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? ☐ No ☐ Yes
3. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
- confined at home, in a hospital, or in a treatment facility ☐ No ☐ Yes
  - who incurred more than \$10,000 of medical expenses in the past 24 months ☐ No ☐ Yes
  - who has been advised within the last 90 days to have surgery or be hospitalized ☐ No ☐ Yes
4. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 24 months for any of the following:

• AIDS or an AIDS-related complex or other immune system disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	• Diabetes or any disease or disorder of the kidneys, liver or lungs	<input type="checkbox"/> No <input type="checkbox"/> Yes
• Alcohol or drug abuse or dependence, or psychological disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	• Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes
• Cancer or cancerous tumor	<input type="checkbox"/> No <input type="checkbox"/> Yes	• Heart or vascular disease or stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
• Organ transplant (other than corneal)	<input type="checkbox"/> No <input type="checkbox"/> Yes		

If you answered yes to questions 1-4 above, please indicate the question number and explanation. Attach additional signed and dated sheets (reorder GN-52334), if necessary.

Question #	Member Status*	Age	Medical Condition/ Diagnosis	Date(s) of Treatment	Medication Name/ Dosage	Past/Current/Future Treatment

\* Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree Class

Has your company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?

☐ No ☐ Yes If yes, please explain: \_\_\_\_\_

Have any medical benefits now, or within the past 24 months, been funded by you in any manner other than health insurance premium payment?

☐ No ☐ Yes If yes, please provide details and attach medical claims experience for the applicable time period up to 24 months.]

**[a-g]. DENTAL PLANS** (all group sizes)

	Plan 1	Plan 2
<b>Plan name</b> (as shown on your proposal)		
Funding type	<input type="checkbox"/> Employer sponsored <input type="checkbox"/> Voluntary	<input type="checkbox"/> Employer sponsored <input type="checkbox"/> Voluntary
Coinsurance	In ____% / / Out ____% / /	In ____% / / Out ____% / /
Deductible	In \$ Out \$	In \$ Out \$
Annual maximum	\$	\$
Preventive services deductible options	<input type="checkbox"/> Apply deductible <input type="checkbox"/> Waive deductible	<input type="checkbox"/> Apply deductible <input type="checkbox"/> Waive deductible
Periodontic/Endodontic options	<input type="checkbox"/> Basic <input type="checkbox"/> Major	<input type="checkbox"/> Basic <input type="checkbox"/> Major
Composite fillings for molars	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Implant coverage	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Orthodontia options	<input type="checkbox"/> Child only: lifetime ortho max \$ _____ <input type="checkbox"/> Adult & child: lifetime ortho max \$ _____	<input type="checkbox"/> Child only: lifetime ortho max \$ _____ <input type="checkbox"/> Adult & child: lifetime ortho max \$ _____
Out of network reimbursement options	<input type="checkbox"/> Max allowable fee <input type="checkbox"/> In-network fee schedule	<input type="checkbox"/> Max allowable fee <input type="checkbox"/> In-network fee schedule
Oral Surgery Covered In Basic	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Open Enrollment	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**[a-g]. LIFE** (all group sizes) - Please refer to your proposal

**Basic Employee Life and AD&D** (AD&D only applicable to certain plans)

- ☐ Flat amount—indicate level: \$\_\_\_\_\_ Increment (if applicable) \$\_\_\_\_\_
- ☐ Salary plan—options are 1x to 6x salary, rounded to the next highest \$1,000. Indicate salary level: \_\_\_\_\_ x salary
- ☐ Class schedule—no more than 2.5 times between the classes and 10 times between the lowest and highest class (complete table below).

Class	Description	Benefit Amount / Salary Factor
I		
II		
III		
IV		

**Rate Guarantee (only available with certain plans)** ☐ 2 Year ☐ 3 Year

**Age Reduction (only available with certain plans)**

If you are also selecting Voluntary Life Age Reduction, age reduction values between Basic Employee and Voluntary Life must match.

☐ \_\_\_\_\_ ☐ \_\_\_\_\_ ☐ \_\_\_\_\_ ☐ \_\_\_\_\_ ☐ \_\_\_\_\_

**Basic Dependent Life** ☐ No ☐ Yes If yes, indicate volume amount ☐ \$20,000/\$5,000 ☐ \$10,000/2,500 ☐ \$5,000/\$1,000

**[Voluntary Life**

Voluntary Employee Life ☐ No ☐ Yes If yes, do you want to select AD&D? ☐ No ☐ Yes

Voluntary Dependent Life (Available only when enrolled in Voluntary Life) ☐ No ☐ Yes

**[Age Reduction (only available with certain plans)**

If you are also selecting Basic Employee Age Reduction, age reduction values between Basic Employee and Voluntary Life must match.]

☐ \_\_\_\_\_ ☐ \_\_\_\_\_ ☐ \_\_\_\_\_ ☐ \_\_\_\_\_ ☐ \_\_\_\_\_

[Portability of coverage (Applicable to Voluntary Life only) ☐ No ☐ Yes]]

**[a-g]. VISION PLANS** (all group sizes)

	Plan 1	Plan 2
Plan name (as shown on your proposal)		

**Vision Options** (For groups 100+ with a custom vision plan, please list the in-network benefit options below.)

Funding type	<input type="checkbox"/> Employer sponsored <input type="checkbox"/> Voluntary	<input type="checkbox"/> Employer sponsored <input type="checkbox"/> Voluntary
Exam / material copayment	/	/
Frame allowance		
Contact lens allowance		
Frequency		

**[a-g]. SHORT TERM DISABILITY (group sizes 10+)** Attach additional signed and dated sheets (reorder GN-52336), if necessary.

<b>Name of Class 1</b>	
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary
Benefit schedule (select one)	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66.67% <input type="checkbox"/> Other _____ <input type="checkbox"/> Flat amount \$ _____ <input type="checkbox"/> Incremental amount \$ _____
Weekly benefit minimum	\$ _____
Weekly benefit maximum	\$ _____
Earnings definition	<input type="checkbox"/> Base salary <input type="checkbox"/> Average _____ months bonus <input type="checkbox"/> Average _____ months commission <input type="checkbox"/> Other _____
Duration weeks	<input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> Other _____
Elimination period (accident/sickness)	<input type="checkbox"/> 1/8 <input type="checkbox"/> 8/8 <input type="checkbox"/> 15/15 <input type="checkbox"/> 30/30 <input type="checkbox"/> Other _____
Pre-existing limitation	<input type="checkbox"/> None <input type="checkbox"/> 3/3/12 <input type="checkbox"/> Other _____
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Other _____

<b>Name of Class 2</b>	
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary
Benefit schedule (select one)	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66.67% <input type="checkbox"/> Other _____ <input type="checkbox"/> Flat amount \$ _____ <input type="checkbox"/> Incremental amount \$ _____
Weekly benefit minimum	\$ _____
Weekly benefit maximum	\$ _____
Earnings definition	<input type="checkbox"/> Base salary <input type="checkbox"/> Average _____ months bonus <input type="checkbox"/> Average _____ months commission <input type="checkbox"/> Other _____
Duration weeks	<input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> Other _____
Elimination period (accident/sickness)	<input type="checkbox"/> 1/8 <input type="checkbox"/> 8/8 <input type="checkbox"/> 15/15 <input type="checkbox"/> 30/30 <input type="checkbox"/> Other _____
Pre-existing limitation	<input type="checkbox"/> None <input type="checkbox"/> 3/3/12 <input type="checkbox"/> Other _____
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Other _____

**[a-g]. LONG TERM DISABILITY (group sizes 10+)** Attach additional signed and dated sheets (reorder GN-52336), if necessary.

<b>Name of Class 1</b>	
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary
Benefit schedule (select one)	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66.67% <input type="checkbox"/> Other _____ <input type="checkbox"/> Incremental amount \$ _____
Monthly benefit minimum	<input type="checkbox"/> \$100 or 10% of monthly salary <input type="checkbox"/> Other _____
Monthly benefit maximum	\$ _____
Earnings definition	<input type="checkbox"/> Base salary <input type="checkbox"/> Average _____ months bonus <input type="checkbox"/> Average _____ months commission <input type="checkbox"/> Other _____
Duration	<input type="checkbox"/> 2 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> SSNRA <input type="checkbox"/> Other _____
Elimination period	Days: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> Other _____
Definition of disability	Year own occupation: <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> to age 65 <input type="checkbox"/> Other _____
Pre-existing limitation	<input type="checkbox"/> 3/3/12 <input type="checkbox"/> 6/6/12 <input type="checkbox"/> 3/12 <input type="checkbox"/> 6/12 <input type="checkbox"/> Other _____
Mental health and substance abuse limitation	<input type="checkbox"/> 24-month outpatient <input type="checkbox"/> 12-month outpatient <input type="checkbox"/> Other _____
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Other _____

**[a-g]. LONG TERM DISABILITY (group sizes 10+)** (continued)

<b>Name of Class 2</b>	
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary
Benefit schedule (select one)	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66.67% <input type="checkbox"/> Other _____ <input type="checkbox"/> Incremental amount \$ _____
Monthly benefit minimum	<input type="checkbox"/> \$100 or 10% of monthly salary <input type="checkbox"/> Other _____
Monthly benefit maximum	\$ _____
Earnings definition	<input type="checkbox"/> Base salary <input type="checkbox"/> Average _____ months bonus <input type="checkbox"/> Average _____ months commission <input type="checkbox"/> Other _____
Duration	<input type="checkbox"/> 2 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> SSNRA <input type="checkbox"/> Other _____
Elimination period	Days: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> Other _____
Definition of disability	Year own occupation: <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> to age 65 <input type="checkbox"/> Other _____
Pre-existing limitation	<input type="checkbox"/> 3/3/12 <input type="checkbox"/> 6/6/12 <input type="checkbox"/> 3/12 <input type="checkbox"/> 6/12 <input type="checkbox"/> Other _____
Mental health and substance abuse limitation	<input type="checkbox"/> 24-month outpatient <input type="checkbox"/> 12-month outpatient <input type="checkbox"/> Other _____
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Other _____

**Additional benefits:** Please refer to your proposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder GN-52336), if necessary.

Cost of living adjustment (3%)	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, <input type="checkbox"/> Lesser of 3% or 1/2 CPI <input type="checkbox"/> Lesser of 6% or 1/2 CPI Select number of adjustments <input type="checkbox"/> 5 <input type="checkbox"/> 10
Activities of daily living	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Additional maximum amount <input type="checkbox"/> 10% <input type="checkbox"/> 20% <input type="checkbox"/> 30% <input type="checkbox"/> 40%
Business income protection	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, <input type="checkbox"/> 15% to \$2,500 <input type="checkbox"/> 25% to \$5,000
Special conditions limitation	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, <input type="checkbox"/> None <input type="checkbox"/> 12 months <input type="checkbox"/> 24 months
Survivor income benefit	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, <input type="checkbox"/> 3 month gross lump sum <input type="checkbox"/> 6 month gross lump sum
Infectious & contagious disease	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Waiting period: <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months Earnings loss: <input type="checkbox"/> 20% <input type="checkbox"/> 40% Duration of benefits: <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> Duration of claim Benefits cease if earnings exceed: <input type="checkbox"/> 80 % <input type="checkbox"/> 60 %
Accidental dismemberment and loss of sight	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Loss occurs within: <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days
Extended earnings	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Qualification for benefit: <input type="checkbox"/> Less than 60% of PDE <input type="checkbox"/> Less than 80% of PDE <input type="checkbox"/> Less than 100% of PDE Benefit end date: _____ The lesser of <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 6 <input type="checkbox"/> 3 months or when earnings exceed qualification %
Pension contribution	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medical premium supplemental	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Duration of Benefits: <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> Duration of claim

**[a-g]. WORKPLACE VOLUNTARY BENEFITS** (all group sizes)

<b>[DISABILITY INCOME PLUS]</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>[Plan design]</b> <input type="checkbox"/> Benefits are provided in conjunction with an HSA plan <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan	
[Benefit period (select all that apply)]	<input type="checkbox"/> [1-24] Months	<input type="checkbox"/> [1-24] Months	<input type="checkbox"/> [1-3] Years <input type="checkbox"/> [1-3] Years <input type="checkbox"/> [1-3] Years
[Elimination period (select all that apply)]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]
	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]
	<input type="checkbox"/> [0-730] / [0-730]		
<b>[Optional Benefits - Employer Selectable]</b> <input type="checkbox"/> Loss of work <input type="checkbox"/> 24-hour coverage <input type="checkbox"/> Takeover <input type="checkbox"/> Mental, nervous, alcohol and drug abuse <input type="checkbox"/> Portability <input type="checkbox"/> Sickness elimination period waiver (available only if 7- or 14-day elimination period is selected for sickness)			
<b>[Optional Benefits - Employee Selectable]</b> <input type="checkbox"/> COBRA benefit <input type="checkbox"/> Physical Therapy <input type="checkbox"/> ICU/CCU			
<input type="checkbox"/> Disability Income Advantage			
[Base Benefit period (select all that apply)]	<input type="checkbox"/> [1-24] Months	<input type="checkbox"/> [1-24] Months	<input type="checkbox"/> [1-3] Years <input type="checkbox"/> [1-3] Years <input type="checkbox"/> [1-3] Years
[Elimination period (select all that apply)]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]
	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]
	<input type="checkbox"/> [0-730] / [0-730]		
<b>[Optional Riders]</b> <input type="checkbox"/> 24-hour coverage <input type="checkbox"/> Hospital confinement <input type="checkbox"/> Takeover <input type="checkbox"/> COBRA <input type="checkbox"/> Limited mental health/Emotional disease (only available with EP 0/14, 14/14, or 30/30)			
<input type="checkbox"/> Income Protector (Non-Occ)			
[Elimination period (select all that apply)]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]
	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730]	<input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]
	<input type="checkbox"/> [0-730] / [0-730]		
[Benefit period (select all that apply)]	<input type="checkbox"/> [1-90] Days	<input type="checkbox"/> [1-24] Months	<input type="checkbox"/> [1-2] Years <input type="checkbox"/> [1-2] Years
<b>[Optional Riders]</b> <input type="checkbox"/> Emergency Accident <input type="checkbox"/> Outpatient Sickness <input type="checkbox"/> Hospital Indemnity			
<b>[ACCIDENT]</b> <input type="checkbox"/> Group <input type="checkbox"/> Trust <input type="checkbox"/> Individual <b>[Base Plan]</b> <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3 <input type="checkbox"/> Level 4			
<input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan			
<b>[Optional Riders]</b> <input type="checkbox"/> Hospital Intensive Care (per day) <input type="checkbox"/> [\$1-1,000] <input type="checkbox"/> [\$1-1,000] <input type="checkbox"/> [\$1-1,000] <input type="checkbox"/> [\$1-1,000] <input type="checkbox"/> [\$1-1,000]			
(May not be available with all plans.)	<input type="checkbox"/> Fracture and dislocation	<input type="checkbox"/> [\$1-1,000] <input type="checkbox"/> [\$1-1,000]	
	<input type="checkbox"/> Accident total disability (elimination period)	<input type="checkbox"/> [1-45] [Day(s)][Month(s)][Year(s)]	<input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)]
		<input type="checkbox"/> [1-45] [Day(s)][Month(s)][Year(s)]	<input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)]
	<input type="checkbox"/> On-the-job coverage <input type="checkbox"/> Travel/Lodging	<input type="checkbox"/> Loss of work]]	
<b>[CRITICAL ILLNESS]</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>[Plan design]</b> <input type="checkbox"/> Benefits are provided in conjunction with a HSA plan <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan			
<b>[Coverage choices]</b> <input type="checkbox"/> Vascular <input type="checkbox"/> Cancer <input type="checkbox"/> Other critical illnesses [50 or] 100% of face amount			
<b>[Optional Benefits - Employer Selectable]</b> <input type="checkbox"/> Benefit recurrence <input type="checkbox"/> Loss of work <input type="checkbox"/> Takeover			
<b>[Optional Benefits - Employee Selectable]</b> <input type="checkbox"/> Health screening benefit \$_____ <input type="checkbox"/> Automatic benefit increase]]			
<b>[CRITICAL ILLNESS (Employer paid)]</b> <b>[Plan design]</b> <input type="checkbox"/> Benefits offered in conjunction with an IRS-qualified pre-tax plan			
<b>[Coverage choices]</b> <input type="checkbox"/> Vascular <input type="checkbox"/> Cancer <input type="checkbox"/> Other group critical illness [50 or] 100% of face amount			
<b>[Optional Benefits - Employer Selectable]</b> <input type="checkbox"/> None <input type="checkbox"/> Benefit recurrence			
	<input type="checkbox"/> Takeover	<input type="checkbox"/> Health screening: ]	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> [\$1-500]
	<input type="checkbox"/> Loss of work		
<b>[Face amount (employee/member)]</b>	<input type="checkbox"/> Class I Basic: \$_____	<input type="checkbox"/> Class I Buy-up/Optional: \$_____	
	<input type="checkbox"/> Class II Basic: \$_____	<input type="checkbox"/> Class II Buy-up/Optional: \$_____	
<b>[Family options]</b>	<input type="checkbox"/> Spouse Basic: \$_____ or _____% of employee/member amount	<input type="checkbox"/> Buy-up/Optional: \$_____ or _____% of employee/member amount	
	<input type="checkbox"/> Child(ren) Basic: \$_____ or _____% of employee/member amount	<input type="checkbox"/> Buy-up/Optional: \$_____ or _____% of employee/member amount	
<b>[Maximum benefit amount]</b>	<input type="checkbox"/> Basic: \$_____	<input type="checkbox"/> Buy-up/Optional: \$_____	



**[a-g]. WORKPLACE VOLUNTARY BENEFITS** (continued)

<b>[CRITICAL LIFE]</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>[Plan design]</b> <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)]																																											
<b>[Optional Benefits - Employer Selectable]</b> <input type="checkbox"/> Waiver of premium <input type="checkbox"/> Loss of work <input type="checkbox"/> Takeover <input type="checkbox"/> Additional benefit increase <input type="checkbox"/> Accelerated living benefit - critical illness ____ % <input type="checkbox"/> Accidental death and loss of sight dismemberment																																												
<b>[CANCER]</b> <input type="checkbox"/> Cancer Expense <input type="checkbox"/> Group Lump Sum Cancer <input type="checkbox"/> Cancer Lump Sum 10-50 <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan <b>[Optional Riders - Cancer Expense]</b> <input type="checkbox"/> Hospital indemnity <input type="checkbox"/> Lump sum first diagnosis <b>[Optional Riders - Cancer Lump Sum 10-50]</b> <input type="checkbox"/> Lifetime pay <input type="checkbox"/> 20 Pay <input type="checkbox"/> Return of premium <b>[Optional Benefits - Group Lump Sum Cancer Employer selectable]</b> <input type="checkbox"/> Benefit recurrence <input type="checkbox"/> Loss of work <input type="checkbox"/> Takeover benefit <b>[Optional Benefits - Group Lump Sum Cancer Employee selectable]</b> <input type="checkbox"/> Health Screening \$ _____ <input type="checkbox"/> Automatic benefit increase																																												
<b>[WHOLE LIFE]</b> <input type="checkbox"/> Whole Life 65 <input type="checkbox"/> Whole Life 90 <input type="checkbox"/> Whole Life 99 <b>[Optional Riders]</b> <input type="checkbox"/> Waiver of premium <input type="checkbox"/> AD&D <input type="checkbox"/> Loss of work <input type="checkbox"/> Automatic benefit increase <input type="checkbox"/> Family Term <input type="checkbox"/> Employee Term to Age 65																																												
<b>[HEALTH CARE PLUS]</b> <input type="checkbox"/> Hospital Confinement Benefit <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan <b>[Optional Riders]</b> <input type="checkbox"/> Hospital Indemnity																																												
<b>[SUPPLEMENTAL HEALTH]</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan  <div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> <b>[Base plan]</b>    <input type="checkbox"/> Plan A)    <input type="checkbox"/> Plan B)    <input type="checkbox"/> Plan C)    <input type="checkbox"/> Plan D)         </div> </div> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">[Hospital Indemnity]</td> <td style="width: 20%;">[\$100/day]</td> <td style="width: 20%;">[\$200/day]</td> <td style="width: 20%;">[\$300/day]</td> <td style="width: 20%;">[\$500/day]</td> </tr> <tr> <td>[Hospital First Occurrence]</td> <td>[\$250/day]</td> <td>[\$500/day]</td> <td>[\$500/day (days 1-2)] [\$750/day (days 3-4)]</td> <td>[\$500/day (days 1-2)] [\$1,000/day (days 3-4)]</td> </tr> </table> <b>[Optional benefits - Employer selectable]</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><input type="checkbox"/> Emergency Room</td> <td style="width: 20%;">[\$50/day (ER)] [\$40/day (urgent care)]</td> <td style="width: 20%;">[\$100/day (ER)] [\$80/day (urgent care)]</td> <td style="width: 20%;">[\$150/day (ER)] [\$120/day (urgent care)]</td> <td style="width: 20%;">[\$250/day (ER)] [\$200/day (urgent care)]</td> </tr> <tr> <td><input type="checkbox"/> ICU/CCU/Burn Unit benefit</td> <td>[\$100/day]</td> <td>[\$200/day]</td> <td>[\$600/day]</td> <td>[\$1,000/day]</td> </tr> <tr> <td><input type="checkbox"/> Surgical Schedule</td> <td>[\$500]</td> <td>[\$1,000]</td> <td>[\$1,000]</td> <td>[\$2,000]</td> </tr> <tr> <td><input type="checkbox"/> Diagnostic, laboratory and x-ray</td> <td>[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]</td> <td>[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]</td> <td>[\$50/test (hospital)] [\$40/test (doctor's office or clinic)]</td> <td>[\$75/test (hospital)] [\$60/test (doctor's office or clinic)]</td> </tr> <tr> <td><input type="checkbox"/> Outpatient office visit</td> <td>[\$25]</td> <td>[\$50]</td> <td>[\$75]</td> <td>[\$100]</td> </tr> <tr> <td><input type="checkbox"/> Wellness</td> <td>[\$50]</td> <td>[\$50]</td> <td>[\$100]</td> <td>[\$150]</td> </tr> </table> [If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.]					[Hospital Indemnity]	[\$100/day]	[\$200/day]	[\$300/day]	[\$500/day]	[Hospital First Occurrence]	[\$250/day]	[\$500/day]	[\$500/day (days 1-2)] [\$750/day (days 3-4)]	[\$500/day (days 1-2)] [\$1,000/day (days 3-4)]	<input type="checkbox"/> Emergency Room	[\$50/day (ER)] [\$40/day (urgent care)]	[\$100/day (ER)] [\$80/day (urgent care)]	[\$150/day (ER)] [\$120/day (urgent care)]	[\$250/day (ER)] [\$200/day (urgent care)]	<input type="checkbox"/> ICU/CCU/Burn Unit benefit	[\$100/day]	[\$200/day]	[\$600/day]	[\$1,000/day]	<input type="checkbox"/> Surgical Schedule	[\$500]	[\$1,000]	[\$1,000]	[\$2,000]	<input type="checkbox"/> Diagnostic, laboratory and x-ray	[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$50/test (hospital)] [\$40/test (doctor's office or clinic)]	[\$75/test (hospital)] [\$60/test (doctor's office or clinic)]	<input type="checkbox"/> Outpatient office visit	[\$25]	[\$50]	[\$75]	[\$100]	<input type="checkbox"/> Wellness	[\$50]	[\$50]	[\$100]	[\$150]
[Hospital Indemnity]	[\$100/day]	[\$200/day]	[\$300/day]	[\$500/day]																																								
[Hospital First Occurrence]	[\$250/day]	[\$500/day]	[\$500/day (days 1-2)] [\$750/day (days 3-4)]	[\$500/day (days 1-2)] [\$1,000/day (days 3-4)]																																								
<input type="checkbox"/> Emergency Room	[\$50/day (ER)] [\$40/day (urgent care)]	[\$100/day (ER)] [\$80/day (urgent care)]	[\$150/day (ER)] [\$120/day (urgent care)]	[\$250/day (ER)] [\$200/day (urgent care)]																																								
<input type="checkbox"/> ICU/CCU/Burn Unit benefit	[\$100/day]	[\$200/day]	[\$600/day]	[\$1,000/day]																																								
<input type="checkbox"/> Surgical Schedule	[\$500]	[\$1,000]	[\$1,000]	[\$2,000]																																								
<input type="checkbox"/> Diagnostic, laboratory and x-ray	[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]	[\$50/test (hospital)] [\$40/test (doctor's office or clinic)]	[\$75/test (hospital)] [\$60/test (doctor's office or clinic)]																																								
<input type="checkbox"/> Outpatient office visit	[\$25]	[\$50]	[\$75]	[\$100]																																								
<input type="checkbox"/> Wellness	[\$50]	[\$50]	[\$100]	[\$150]																																								

**[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS**

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4) resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

**[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS**

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility,

underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

**[1-10]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully**

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree, and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this EGA, we will decline to enroll you in an insurance product or to give you insurance benefits.

**DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.**

Dated on: \_\_\_\_\_ (month, date, year) at \_\_\_\_\_ (city and state)

By: \_\_\_\_\_  
(Employer printed name) (Employer signature) (Title)

For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: \_\_\_\_\_  
(Plan sponsor printed name) (Plan sponsor signature) (Title)

**[1-10]. AGENT/BROKER/PRODUCER INFORMATION**

1. Agency of Record (for commissions and correspondence)	2. Agent/Agency of Record (for split commissions)
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (total should equal 100%)	Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (total should equal 100%)
<b>1. Writing Agent/Broker/Producer</b>	<b>2. Writing Agent/Broker/Producer</b>
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (total should equal 100%)	Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: _____ (total should equal 100%)

**General Agency (Complete only if agency involved in sale)**

General agency information pertains to: <input type="checkbox"/> Agency of Record <input type="checkbox"/> Writing Agent			
Name (print or type)	Tax ID/Humana Agent Number		
Address	City	State	ZIP code

As the Writing Agent/Broker/Producer, I acknowledge that I am responsible to meet with the employer submitting this Employer Group Application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent/Broker/Producer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# [2-99] Employer/Group Application - Arkansas



FOR GROUP COVERAGE ([2-99] ELIGIBLE EMPLOYEES)

Humana.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Small Group/Employer Application as "Humana".

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

<b>[1-10]. EMPLOYER COMPANY INFORMATION:</b> Please type or print clearly in black ink						<b>Internal use only</b> Group number:	
Full legal business name							Requested effective date __/__/____
Corporate/Situs location street address (P.O. Box not allowed)				City	State	ZIP code	County
Type of business	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Sole Proprietorship	Date company established		Federal Tax ID	
	<input type="checkbox"/> Church or Government entity	<input type="checkbox"/> Other (explain) _____					
Nature of business/SIC code			Business phone number ( )		Business fax number ( )		
Do you have more than one location? <input type="checkbox"/> No <input type="checkbox"/> Yes							
<b>Benefit Administrator/Management contact name:</b>							
Phone number ( )			Fax number ( )		E-mail		
Management contact: Mother's maiden name _____ (this will be used to gain access to the Employer Self-Service Center on www.Humana.com)							
<b>Billing contact name:</b>							
Billing address (N/A, if same as street address)					City	State	ZIP code
Phone number ( )			Fax number ( )		E-mail		
[Are separate divisions/classes required for billing or reporting? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.]							
<b>[For Workplace Voluntary Benefits:</b> Effective date of policy and due date of first premium will be (month, day, year) __/__/____]							

## [1-10]. ELIGIBILITY REQUIREMENTS

Number of employees on payroll \_\_\_\_\_. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	[All]	[Medical]	[Dental]	[Life]	[Vision]	[STD]	[LTD]	[Group Critical Illness]	[Workplace Voluntary Benefits]
A. Number of hours worked per week to be eligible (select between 20 and 40 hours)									
B. Number of employees in a probationary waiting period (do not include in the eligible count below in C)									
C. Total number of eligible employees	]	]	]	]	]	]	]	]	]

As of the date of this application, list any employees currently disabled and not actively at work: (attach additional signed and dated pages, if necessary)

Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify) \_\_\_\_\_  
(if you prefer months, please select "Other" and specify the number of months)

Employee effective provision: [(On all plans, except STD and LTD, the employee termination date coincides with the effective date provision. STD/LTD is immediate.)]

[New ☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]  
[Rehire ☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]

**[1-10]. ELIGIBILITY REQUIREMENTS** (continued)Do you want to exclude a class of employees? ☐ No ☐ Yes

If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)

☐ union ☐ non-union ☐ hourly ☐ salary ☐ management ☐ non-management ☐ other: \_\_\_\_\_**Employee Eligibility by Class**

According to Federal health care reform, an employer's group health plan cannot discriminate in favor of highly-compensated employees. Doing so may result in a penalty. To avoid penalties, please review any class-based benefits with your legal or financial advisor to ensure your group health plan does not favor highly compensated employees. (Excludes grandfathered health plans).

Has this group been insured by Humana within the last three years? ☐ No ☐ Yes

If yes, please provide prior group number and termination date: \_\_\_\_\_

Is this a Collectively Bargained Plan? ☐ No ☐ Yes Name of Plan \_\_\_\_\_  
Plan number \_\_\_\_\_ (Assigned by Employer for use in filing IRS form 5500)Do you wish to offer Domestic Partner coverage? ☐ No ☐ Yes**Retiree information**For groups 26+, are you offering coverage to retirees? ☐ No ☐ Yes If yes, required age \_\_\_\_\_ Minimum years of service \_\_\_\_\_

	All	Medical	Dental	Vision	Life (if applicable)
Number of current retirees to be covered					

Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes If yes, enter information below:

Company name	Total employees

**[Short Term Disability,] [Long Term Disability,] and [Group Critical Illness] only**

Effective dates for changes in amounts of coverage	Effective first day of month following change	Other
Increases/decreases due to change in class	<input type="checkbox"/>	
Increases/decreases requested by employee	<input type="checkbox"/>	
Increases (with Evidence of Insurability) requested by employee	<input type="checkbox"/>	
Decreases due to age	<input type="checkbox"/>	

Evidence of Insurability required if amount of coverage applied for exceeds amounts below:

	Class 1	Class 2		Class 1	Class 2
Employee STD	\$	\$	Basic group critical illness	\$	\$
Employee LTD	\$	\$	Buy-up group critical illness		

☐ **Special requests:** Check box and attach signed additional sheet or letter, if custom dating, face amounts, etc. are desired.**[W-2 Services Option (Please choose one)]**☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 forms.☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 forms services.

A detailed description of the W-2 services elected by applicant pursuant to this Application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established as standard procedures.]

**[1-10]. COBRA/STATE CONTINUATION**Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes

Number of existing COBRA participants	Medical:	Dental:	Vision:
How many in COBRA election period	Medical:	Dental:	Vision:

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes

If yes, enter information below. Attach additional signed and dated sheets (reorder AR-52247), if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date

**[1-10]. EMPLOYER CONTRIBUTION(S)**

[(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes

If yes, indicate amount funded \$ \_\_\_\_\_]

[(STD and LTD only) Are employer contributions taxed in employee's paycheck? ☐ No ☐ Yes]

Coverage - Employer's contribution for:	[Medical]	[Dental]	[Vision]	[Life]	[Voluntary Life]	[STD]	[LTD]	[Workplace Voluntary Benefits]	[Spending Account*]
Employee	%	%	%	%	%	%	%	%	\$
Employee/spouse	%	%	%	%	%	N/A	N/A	%	\$
Employee/child	%	%	%	%	%	N/A	N/A	%	\$
Family	%]	%]	%]	%]	%]	N/A]	N/A]	%]	\$ ]

[\* For medical plans, Humana reserves the right to re-evaluate rates and require new premium prior to underwriting approval or issuing coverage with employer contributions greater than 50% of a plan's deductible to an employee's spending account.]

[Life]	Plan 1	Plan 2
Employee		
Spouse		
Child(ren)		]

**[1-10]. PRIOR/CURRENT CARRIER INFORMATION**

	[Medical]	[Dental]	[Life]	[Vision]	[STD]	[LTD]
Is this group transferring from another group carrier?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, provide carrier name						
Proposed termination date	]	]	]	]	]	]

[Dental only: Did prior dental coverage include orthodontia? ☐ No ☐ Yes]

**[For Workplace Voluntary Benefits - Existing coverage available to employees**

[Disability income carrier \_\_\_\_\_ ☐ Individual ☐ Group Coverage termination date \_\_\_\_\_]  
 [CI/Cancer carrier \_\_\_\_\_ ☐ Individual ☐ Group Coverage termination date \_\_\_\_\_ ]]

[(For Medical only)		Group's renewal date:		
Current carrier rates	Employee \$	Spouse \$	Child(ren) \$	Family \$
Plan design		Office visit copay \$		Per confinement copay \$
Coinsurance In _____% Out _____%		Deductible In _____% Out _____%		Out-of-pocket In _____% Out _____%
Emergency room copay \$		Prescription drug benefit \$		
Renewal rates	Employee \$	Spouse \$	Child(ren) \$	Family \$
How many medical carriers have you had in the past five years?]				

**[1-10]. PRODUCT SELECTION -** To complete this section, please refer to the Underwriting Requirements (reorder AR-52347). Please refer to your quote for the plan's name. Also review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker, or producer.

**[a-i]. MEDICAL PLANS**

	Plan 1	Plan 2	Plan 3
Plan name (as shown in your proposal)			
Office/Specialist copay (if applicable)	\$ / \$	\$ / \$	\$ / \$
Coinsurance	In % / Out %	In % / Out %	In % / Out %
Deductible	In \$ / Out \$	In \$ / Out \$	In \$ / Out \$
Out-of-pocket limit	In \$ / Out \$	In \$ / Out \$	In \$ / Out \$
Prescription drug/Retail card (Level 1 / 2 / 3 / 4)	\$ /\$ /\$ / %	\$ /\$ /\$ / %	\$ /\$ /\$ / %
Prescription drug/Retail card - RxImpact (Group A / B / C / D)	\$ /\$ /\$ /\$	\$ /\$ /\$ /\$	\$ /\$ /\$ /\$
Network name			

**[a-i]. MEDICAL PLANS** (continued)**Additional riders:** Please refer to your proposal for rider availability with plan selected.

	Plan 1	Plan 2	Plan 3
Deductible Carryover Credit	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Supplemental Accident	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
[Employee Assistance Program]	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other:	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Special State Options:</b> Optional Behavioral Health Benefit	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

**Workers' Compensation** (applicable for Medical plans all group sizes)Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? ☐ No ☐ Yes

If yes, name(s):

**[Health Questionnaire for groups enrolling [2-99] employees:** (check all that apply)

- Has any employee been unable to work 10 or more consecutive days in the past 12 months due to an illness or injury? ☐ No ☐ Yes
- Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? ☐ No ☐ Yes
- To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
  - confined at home, in a hospital, or in a treatment facility ☐ No ☐ Yes
  - who incurred more than \$10,000 of medical expenses in the past 24 months ☐ No ☐ Yes
  - who has been advised within the last 90 days to have surgery or be hospitalized ☐ No ☐ Yes
- To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 24 months for any of the following:

• AIDS or an AIDS-related complex or other immune system disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	• Diabetes or any disease or disorder of the kidneys, liver or lungs	<input type="checkbox"/> No <input type="checkbox"/> Yes
• Alcohol or drug abuse or dependence, or psychological disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	• Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes
• Cancer or cancerous tumor	<input type="checkbox"/> No <input type="checkbox"/> Yes	• Heart or vascular disease or stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
• Organ transplant (other than corneal)	<input type="checkbox"/> No <input type="checkbox"/> Yes		

If you answered yes to questions 1-4 above, please indicate the question number and explanation. Attach additional signed and dated sheets (reorder GN-52334), if necessary.

Question #	Member Status*	Age	Medical Condition/ Diagnosis	Date(s) of Treatment	Medication Name/ Dosage	Past/Current/Future Treatment

\* Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree Class

Has your company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?

☐ No ☐ Yes If yes, please explain: \_\_\_\_\_

Have any medical benefits now, or within the past 24 months, been funded by you in any manner other than health insurance premium payment?

☐ No ☐ Yes If yes, please provide details and attach medical claims experience for the applicable time period up to 24 months.]

**[a-i]. DENTAL PLANS** (all group sizes)

	Plan 1	Plan 2
<b>Plan name</b> (as shown on your proposal)		
Funding type	<input type="checkbox"/> Employer sponsored <input type="checkbox"/> Voluntary	<input type="checkbox"/> Employer sponsored <input type="checkbox"/> Voluntary
Coinsurance	In ____% / /    Out ____% / /	In ____% / /    Out ____% / /
Deductible	In \$                      Out \$	In \$                      Out \$
Annual maximum	\$	\$
Preventive services deductible options	<input type="checkbox"/> Apply deductible <input type="checkbox"/> Waive deductible	<input type="checkbox"/> Apply deductible <input type="checkbox"/> Waive deductible
Periodontic/Endodontic options	<input type="checkbox"/> Basic <input type="checkbox"/> Major	<input type="checkbox"/> Basic <input type="checkbox"/> Major
Composite fillings for molars	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Implant coverage	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Orthodontia options	<input type="checkbox"/> Child only: lifetime ortho max \$ _____ <input type="checkbox"/> Adult & child: lifetime ortho max \$ _____	<input type="checkbox"/> Child only: lifetime ortho max \$ _____ <input type="checkbox"/> Adult & child: lifetime ortho max \$ _____
Out of network reimbursement options	<input type="checkbox"/> Max allowable fee <input type="checkbox"/> In-network fee schedule	<input type="checkbox"/> Max allowable fee <input type="checkbox"/> In-network fee schedule
Oral Surgery Covered In Basic	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Open Enrollment	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**[a-i]. LIFE** - Please refer to your proposal**Basic Life****Basic Employee Life**    ☐ No    ☐ YesIf yes, do you want to select AD&D?    ☐ No    ☐ Yes    AD&D optional benefit riders:    ☐ Education    ☐ Coma    ☐ Childcare☐ Flat amount—indicate level: \$ \_\_\_\_\_☐ Salary plan—options are 1x to 7x salary, rounded to the next highest \$1,000. Indicate salary level: \_\_\_\_\_ x salary  
Maximum benefit \$ \_\_\_\_\_☐ Class schedule—no more than 2.5 times between the classes and 10 times between the lowest and highest class (complete table below).

Class	Description	Benefit Amount / Salary Factor
I		
II		
III		
IV		

**Rate Guarantee**    ☐ 2 Year    ☐ 3 Year**Age Reduction** (Refer to your proposal)    Schedule 1 \_\_\_\_\_    Schedule 2 \_\_\_\_\_    Schedule 3 \_\_\_\_\_**Basic Dependent Life**    ☐ No    ☐ Yes    If yes, indicate volume amount    Spouse \$ \_\_\_\_\_    Newborn \$ \_\_\_\_\_  
Infant \$ \_\_\_\_\_    Child/Student \$ \_\_\_\_\_**[Voluntary Life****Voluntary Employee Life**    ☐ No    ☐ YesIf yes, do you want to select AD&D?    ☐ No    ☐ Yes    AD&D optional benefit riders:    ☐ Education    ☐ Coma    ☐ Childcare

Flat amount—indicate level: \$ \_\_\_\_\_

☐ Incremental amount \$ \_\_\_\_\_☐ Maximum benefit \$ \_\_\_\_\_☐ Salary plan—options are 1x to 7x salary, rounded to the next highest \$1,000. Indicate salary multiple range: \_\_\_\_\_ x salary to \_\_\_\_\_ x salary  
Maximum benefit \$ \_\_\_\_\_

Class	Description	Benefit Amount / Salary Factor
I		
II		
III		
IV		

**[Rate Guarantee**    ☐ 2 Year    ☐ 3 Year]**[Age Reduction** (Refer to your proposal)    Schedule 1 \_\_\_\_\_    Schedule 2 \_\_\_\_\_    Schedule 3 \_\_\_\_\_]**[Portability of coverage** (Applicable to Voluntary Life only)    Groups [2-99]: Included (Unless mandated by state)]]



**[a-i]. VISION PLANS** (all group sizes)

Plan name (as shown on your proposal)

**[a-i]. SHORT TERM DISABILITY (group sizes 2-9).** Attach additional signed and dated sheets (reorder GN-52336), if necessary.

	Name of Class 1	Name of Class 2
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory
Benefit schedule (select one)	<input type="checkbox"/> 60% <input type="checkbox"/> Flat amount \$ _____	<input type="checkbox"/> 60% <input type="checkbox"/> Flat amount \$ _____
Weekly benefit minimum	\$25.00	\$25.00
Weekly benefit maximum	\$	\$
Earnings definition	<input checked="" type="checkbox"/> Base Salary	<input checked="" type="checkbox"/> Base Salary
Duration weeks	<input type="checkbox"/> 13 <input type="checkbox"/> 26	<input type="checkbox"/> 13 <input type="checkbox"/> 26
Elimination period (accident/sickness)	<input type="checkbox"/> 1/8 <input type="checkbox"/> 8/8 <input type="checkbox"/> 15/15 <input type="checkbox"/> 30/30	<input type="checkbox"/> 1/8 <input type="checkbox"/> 8/8 <input type="checkbox"/> 15/15 <input type="checkbox"/> 30/30
Pre-existing limitation	<input checked="" type="checkbox"/> 3/12	<input checked="" type="checkbox"/> 3/12
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input checked="" type="checkbox"/> 2 Years	<input checked="" type="checkbox"/> 2 Years

**[a-i]. LONG TERM DISABILITY (group sizes 2-9).** Attach additional signed and dated sheets (reorder GN-52336), if necessary.

	Name of Class 1	Name of Class 2
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory
Benefit schedule (select one)	<input checked="" type="checkbox"/> 60%	<input checked="" type="checkbox"/> 60%
Monthly benefit minimum	<input checked="" type="checkbox"/> Greater of \$100 or 10% of monthly income loss	<input checked="" type="checkbox"/> Greater of \$100 or 10% of monthly income loss
Monthly benefit maximum	\$	\$
Duration	<input type="checkbox"/> 5 Years <input type="checkbox"/> SSNRA	<input type="checkbox"/> 5 Years <input type="checkbox"/> SSNRA
Elimination period	Days: <input type="checkbox"/> 90 <input type="checkbox"/> 180	Days: <input type="checkbox"/> 90 <input type="checkbox"/> 180
Definition of disability	Year own occupation: <input checked="" type="checkbox"/> 2	Year own occupation: <input checked="" type="checkbox"/> 2
Pre-existing limitation	<input checked="" type="checkbox"/> 12/24	<input checked="" type="checkbox"/> 12/24
Mental health and substance abuse limitation	<input checked="" type="checkbox"/> 24-month outpatient	<input checked="" type="checkbox"/> 24-month outpatient
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input checked="" type="checkbox"/> 2 Years	<input checked="" type="checkbox"/> 2 Years
Survivor income benefit	<input checked="" type="checkbox"/> 3 month gross lump sum	<input checked="" type="checkbox"/> 3 month gross lump sum



**[a-i]. SHORT TERM DISABILITY (group sizes 10+)** Attach additional signed and dated sheets (reorder GN-52336), if necessary.

<b>Name of Class 1</b>	
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary
Benefit schedule (select one)	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66.67% <input type="checkbox"/> Other _____ <input type="checkbox"/> Flat amount \$ _____
Weekly benefit minimum	\$25.00
Weekly benefit maximum	\$
Earnings definition	<input checked="" type="checkbox"/> Base Salary
Duration weeks	<input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> Other _____
Elimination period (Accident/Sickness)	<input type="checkbox"/> 1/8 <input type="checkbox"/> 8/8 <input type="checkbox"/> 15/15 <input type="checkbox"/> 30/30 <input type="checkbox"/> Other _____
Pre-existing limitation	<input type="checkbox"/> None <input type="checkbox"/> 3/12 <input type="checkbox"/> 6/12 <input type="checkbox"/> Other _____
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Other _____
<b>Name of Class 2</b>	
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary
Benefit schedule (select one)	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66.67% <input type="checkbox"/> Other _____ <input type="checkbox"/> Flat amount \$ _____
Weekly benefit minimum	\$25.00
Weekly benefit maximum	\$
Earnings definition	<input checked="" type="checkbox"/> Base Salary
Duration weeks	<input type="checkbox"/> 13 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> Other _____
Elimination period (Accident/Sickness)	<input type="checkbox"/> 1/8 <input type="checkbox"/> 8/8 <input type="checkbox"/> 15/15 <input type="checkbox"/> 30/30 <input type="checkbox"/> Other _____
Pre-existing limitation	<input type="checkbox"/> None <input type="checkbox"/> 3/12 <input type="checkbox"/> 6/12 <input type="checkbox"/> Other _____
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Other _____

**[a-i]. LONG TERM DISABILITY (group sizes 10+)** Attach additional signed and dated sheets (reorder GN-52336) if necessary.

<b>Name of Class 1</b>	
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary
Benefit schedule (select one)	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66.67% <input type="checkbox"/> Other _____
Monthly benefit minimum	<input checked="" type="checkbox"/> Greater of \$100 or 10% of Monthly Income Loss
Monthly benefit maximum	\$
Earnings definition	<input checked="" type="checkbox"/> Base Salary
Duration	<input type="checkbox"/> 2 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> SSNRA <input type="checkbox"/> Other _____
Elimination period	Days: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> Other _____
Definition of disability	Year own occupation: <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> to age 65 <input type="checkbox"/> Other _____
Pre-existing limitation	<input type="checkbox"/> 3/3/12 <input type="checkbox"/> 6/6/12 <input type="checkbox"/> 12/12/24 <input type="checkbox"/> 3/6/12 <input type="checkbox"/> 6/6/24 <input type="checkbox"/> Other _____
Mental health and substance abuse limitation	<input type="checkbox"/> 24-month outpatient <input type="checkbox"/> 12-month outpatient <input type="checkbox"/> Other _____
Waiting period: current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: rehired/new employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate guarantee	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Other _____

**[a-i]. LONG TERM DISABILITY (group sizes 10+)** (continued)

<b>Name of Class 2</b>	
Funding type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-contributory <input type="checkbox"/> Voluntary
Benefit schedule (select one)	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66.67% <input type="checkbox"/> Other _____
Monthly benefit minimum	<input checked="" type="checkbox"/> Greater of \$100 or 10% of Monthly Income Loss
Monthly benefit maximum	\$ _____
Earnings definition	<input checked="" type="checkbox"/> Base Salary
Duration	<input type="checkbox"/> 2 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> SSNRA <input type="checkbox"/> Other _____
Elimination period	Days: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> Other _____
Definition of disability	Year own occupation: <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> to age 65 <input type="checkbox"/> Other _____
Pre-existing limitation	<input type="checkbox"/> 3/3/12 <input type="checkbox"/> 6/6/12 <input type="checkbox"/> 12/12/24 <input type="checkbox"/> 3/6/12 <input type="checkbox"/> 6/6/24 <input type="checkbox"/> Other _____
Mental health and substance abuse limitation	<input type="checkbox"/> 24-month outpatient <input type="checkbox"/> 12-month outpatient <input type="checkbox"/> Other _____
Waiting period: Current employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Waiting period: Rehired/New employees	<input type="checkbox"/> Eligible on date of employment <input type="checkbox"/> Eligible after active employment for _____ days
Rate Guarantee	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Other _____

**Additional benefits:** Please refer to your proposal for additional benefits available with plan selected. Attach additional signed and dated sheets (reorder GN-52336), if necessary.

Cost of living adjustment (3%)	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, <input checked="" type="checkbox"/> lesser of 3% or 1/2 CPI, select number of adjustments <input type="checkbox"/> 5 <input type="checkbox"/> 10
Activities of daily living	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, select additional maximum amount <input type="checkbox"/> 10% <input type="checkbox"/> 20% <input type="checkbox"/> 30% <input type="checkbox"/> 40%
Business income protection	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, <input checked="" type="checkbox"/> 25% to \$5,000
Special conditions limitation	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, <input checked="" type="checkbox"/> 24 months
Survivor income benefit	<input type="checkbox"/> 3-month gross lump sum <input type="checkbox"/> 6-month gross lump sum

**[a-i]. WORKPLACE VOLUNTARY BENEFITS** (all group sizes)

<b>[DISABILITY INCOME PLUS]</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>[Plan design]</b> <input type="checkbox"/> Benefits are provided in conjunction with an HSA plan <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan	
[Benefit period (select all that apply)] <input type="checkbox"/> [1-24] Months <input type="checkbox"/> [1-24] Months <input type="checkbox"/> [1-3] Years <input type="checkbox"/> [1-3] Years <input type="checkbox"/> [1-3] Years [Elimination period (select all that apply)] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]	
<b>[Optional Benefits - Employer Selectable]</b> <input type="checkbox"/> Loss of work <input type="checkbox"/> 24-hour coverage <input type="checkbox"/> Takeover <input type="checkbox"/> Mental, nervous, alcohol and drug abuse <input type="checkbox"/> Portability <input type="checkbox"/> Sickness elimination period waiver (available only if 7- or 14-day elimination period is selected for sickness)	
<b>[Optional Benefits - Employee Selectable]</b> <input type="checkbox"/> COBRA benefit <input type="checkbox"/> Physical Therapy <input type="checkbox"/> ICU/CCU	
<input type="checkbox"/> Disability Income Advantage [Base Benefit period (select all that apply)] <input type="checkbox"/> [1-24] Months <input type="checkbox"/> [1-24] Months <input type="checkbox"/> [1-3] Years <input type="checkbox"/> [1-3] Years <input type="checkbox"/> [1-3] Years [Elimination period (select all that apply)] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]	
<b>[Optional Riders]</b> <input type="checkbox"/> 24-hour coverage <input type="checkbox"/> Hospital confinement <input type="checkbox"/> Takeover <input type="checkbox"/> COBRA <input type="checkbox"/> Limited mental health/Emotional disease (only available with EP 0/14, 14/14, or 30/30)	
<input type="checkbox"/> Income Protector (Non-Occ) [Elimination period (select all that apply)] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730] <input type="checkbox"/> [0-730] / [0-730]	
[Benefit period (select all that apply)] <input type="checkbox"/> [1-90] Days <input type="checkbox"/> [1-24] Months <input type="checkbox"/> [1-2] Years <input type="checkbox"/> [1-2] Years <b>[Optional Riders]</b> <input type="checkbox"/> Emergency Accident <input type="checkbox"/> Outpatient Sickness <input type="checkbox"/> Hospital Indemnity	

**[a-i]. WORKPLACE VOLUNTARY BENEFITS** (continued)

<b>[ACCIDENT]</b> <input type="checkbox"/> Group <input type="checkbox"/> Trust <input type="checkbox"/> Individual <b>[Base Plan]</b> <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3 <input type="checkbox"/> Level 4 <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan <b>[Optional Riders]</b> <input type="checkbox"/> Hospital Intensive Care (per day) <input type="checkbox"/> [\$ 1-1,000] <input type="checkbox"/> [\$ 1-1,000] <input type="checkbox"/> [\$ 1-1,000] <input type="checkbox"/> [\$ 1-1,000] <input type="checkbox"/> [\$ 1-1,000] (May not be <input type="checkbox"/> Fracture and dislocation <input type="checkbox"/> [\$ 1-1,000] <input type="checkbox"/> [\$ 1-1,000] available <input type="checkbox"/> Accident total disability (elimination period) <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] with all plans.) <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> On-the-job coverage <input type="checkbox"/> Travel/Lodging <input type="checkbox"/> Loss of work]]				
<b>[CRITICAL ILLNESS]</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>[Plan design]</b> <input type="checkbox"/> Benefits are provided in conjunction with a HSA plan <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan <b>[Coverage choices]</b> <input type="checkbox"/> Vascular <input type="checkbox"/> Cancer <input type="checkbox"/> Other critical illnesses [50 or] 100% of face amount <b>[Optional Benefits - Employer Selectable]</b> <input type="checkbox"/> Benefit recurrence <input type="checkbox"/> Loss of work <input type="checkbox"/> Takeover <b>[Optional Benefits - Employee Selectable]</b> <input type="checkbox"/> Health screening benefit \$ _____ <input type="checkbox"/> Automatic benefit increase]]				
<b>[CRITICAL LIFE]</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>[Plan design]</b> <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <input type="checkbox"/> [1-45] [Day(s)] [Month(s)] [Year(s)] <b>[Optional Benefits - Employer Selectable]</b> <input type="checkbox"/> Waiver of premium <input type="checkbox"/> Loss of work <input type="checkbox"/> Takeover <input type="checkbox"/> Additional benefit increase <input type="checkbox"/> Accelerated living benefit - critical illness ____ % <input type="checkbox"/> Accidental death and loss of sight dismemberment]				
<b>[CANCER]</b> <input type="checkbox"/> Cancer Expense <input type="checkbox"/> Group Lump Sum Cancer <input type="checkbox"/> Cancer Lump Sum 10-50 <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan <b>[Optional Riders - Cancer Expense]</b> <input type="checkbox"/> Hospital indemnity <input type="checkbox"/> Lump sum first diagnosis <b>[Optional Riders - Cancer Lump Sum 10-50]</b> <input type="checkbox"/> Lifetime pay <input type="checkbox"/> 20 Pay <input type="checkbox"/> Return of premium <b>[Optional Benefits - Group Lump Sum Cancer Employer selectable]</b> <input type="checkbox"/> Benefit recurrence <input type="checkbox"/> Loss of work <input type="checkbox"/> Takeover benefit <b>[Optional Benefits - Group Lump Sum Cancer Employee selectable]</b> <input type="checkbox"/> Health Screening \$ _____ <input type="checkbox"/> Automatic benefit increase]				
<b>[WHOLE LIFE]</b> <input type="checkbox"/> Whole Life 65 <input type="checkbox"/> Whole Life 90 <input type="checkbox"/> Whole Life 99 <b>[Optional Riders]</b> <input type="checkbox"/> Waiver of premium <input type="checkbox"/> AD&D <input type="checkbox"/> Loss of work <input type="checkbox"/> Automatic benefit increase <input type="checkbox"/> Family Term <input type="checkbox"/> Employee Term to Age 65]				
<b>[HEALTH CARE PLUS]</b> [Hospital Confinement Benefit] <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan <b>[Optional Riders]</b> <input type="checkbox"/> Hospital Indemnity]				
<b>[SUPPLEMENTAL HEALTH]</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Benefits will be offered in conjunction with an IRS-qualified pre-tax plan  <div style="display: flex; justify-content: space-between;"> <div></div> <div><b>[Base plan]</b></div> <div><input type="checkbox"/> Plan A</div> <div><input type="checkbox"/> Plan B</div> <div><input type="checkbox"/> Plan C</div> <div><input type="checkbox"/> Plan D</div> </div> <div style="display: flex; justify-content: space-between;"> <div>[Hospital Indemnity]</div> <div>[\$100/day]</div> <div>[\$200/day]</div> <div>[\$300/day]</div> <div>[\$500/day]</div> </div> <div style="display: flex; justify-content: space-between;"> <div>[Hospital First Occurrence]</div> <div>[\$250/day]</div> <div>[\$500/day]</div> <div>[\$500/day (days 1-2)] [\$750/day (days 3-4)]</div> <div>[\$500/day (days 1-2)] [\$1,000/day (days 3-4)]</div> </div> <b>[Optional benefits - Employer selectable]</b> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Emergency Room]</div> <div>[\$50/day (ER)] [\$40/day (urgent care)]</div> <div>[\$100/day (ER)] [\$80/day (urgent care)]</div> <div>[\$150/day (ER)] [\$120/day (urgent care)]</div> <div>[\$250/day (ER)] [\$200/day (urgent care)]</div> </div> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> ICU/CCU/Burn Unit benefit]</div> <div>[\$100/day]</div> <div>[\$200/day]</div> <div>[\$600/day]</div> <div>[\$1,000/day]</div> </div> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Surgical Schedule]</div> <div>[\$500]</div> <div>[\$1,000]</div> <div>[\$1,000]</div> <div>[\$2,000]</div> </div> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Diagnostic, laboratory and x-ray]</div> <div>[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]</div> <div>[\$25/test (hospital)] [\$20/test (doctor's office or clinic)]</div> <div>[\$50/test (hospital)] [\$40/test (doctor's office or clinic)]</div> <div>[\$75/test (hospital)] [\$60/test (doctor's office or clinic)]</div> </div> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Outpatient office visit]</div> <div>[\$25]</div> <div>[\$50]</div> <div>[\$75]</div> <div>[\$100]</div> </div> <div style="display: flex; justify-content: space-between;"> <div><input type="checkbox"/> Wellness]</div> <div>[\$50]</div> <div>[\$50]</div> <div>[\$100]</div> <div>[\$150]</div> </div> [If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.]				

**[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY BENEFITS**

The companies listed on this Employer Group Application (EGA), severally or collectively as the context may require, are referred to in this EGA as we, us, and our.

In accordance with Section 503 of ERISA, as claims administrator we have authority to make decisions consistent with the terms of the Policy or Certificate regarding (1) eligibility for coverage; (2) paying claims for benefits; (3) interpretation of Policy or Certificate provisions; and (4)

resolution of factual questions relating to coverage and benefits.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, plan sponsor and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

**[1-10]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS**

You agree to make available your records which we determine are relevant to this EGA and group coverage for inspection by the Trustee, Administrator, us, or our representative during your normal business hours.

If you fail to pay premium when due, coverage may be subject to termination as specified under the terms of the Policy or Certificate. You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility,

underwriting, participation, and contribution requirements must be maintained, for each respective coverage.

Failure to maintain the plan eligibility, underwriting, participation and contribution requirements will terminate your coverage under the Policy or Certificate.

We have the right to use information provided by you and any employee, dependent or individual to determine whether this EGA will be accepted or declined and to establish appropriate premiums. We will not use any health-related information to decline coverage to an employee, dependent or individual if this EGA is accepted. We will administer this in a non-discriminatory manner.

**[1-10]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully**

You the employer, policyholder, contract holder, or Certificate sponsor understand, agree and represent: You have read this Employer/Group Application (EGA) and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed the quote and the applicable required regulatory information. Neither you nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. For action to be taken on this EGA, the first month's estimated premium (which may include a monthly administrative fee) and fully completed enrollment information for all employees and dependents must be submitted with the EGA. Coverage is not in effect unless and until you receive written notification from us. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. This EGA will form part of any contract or coverage issued. If this EGA is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this EGA, we will decline to enroll you in an insurance product or to give you insurance benefits.

**DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.**

Dated on: \_\_\_\_\_ (month, date, year) at \_\_\_\_\_ (city and state)

By: \_\_\_\_\_  
(Employer printed name) (Employer signature) (Title)

For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: \_\_\_\_\_  
(Plan sponsor printed name) (Plan sponsor signature) (Title)

**[1-10]. AGENT/BROKER/PRODUCER INFORMATION**

<b>1. Agency of Record (for commissions and correspondence)</b>	<b>2. Agent/Agency of Record (for split commissions)</b>
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: (total should equal 100%)	Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: (total should equal 100%)
<b>1. Writing Agent/Broker/Producer</b>	<b>2. Writing Agent/Broker/Producer</b>
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: (total should equal 100%)	Commission split <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage: (total should equal 100%)

**General Agency (Complete only if agency involved in sale)**

General agency information pertains to: <input type="checkbox"/> Agency of Record <input type="checkbox"/> Writing Agent			
Name (print or type)		Tax ID/Humana Agent Number	
Address	City	State	ZIP code

As the Writing Agent/Broker/Producer, I acknowledge that I am responsible to meet with the employer submitting this Employer Group Application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent/Broker/Producer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Group Employee and Individual Application and Enrollment Form - [[2-99] Employees] [Arkansas]**

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Group Employee and Individual Application and Enrollment Form "Humana". To elect primary care physician or dentist, please complete reorder AR-51340-PP.

[Medical plans insured or administered by Humana Insurance Company.] [Dental plans insured or administered] by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Dental HMO plans offered by American Dental Providers of Arkansas, Inc.] [Vision plans insured or administered by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability] [and] [Workplace Voluntary] plans insured by Kanawha Insurance Company.] [Life plans insured or administered by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

Please print clearly and fill in each applicable circle.

Proposed effective date: \_\_/\_\_/\_\_\_\_

Employer / Group name	Employer / Group city	State
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**Qualifying Event Instructions**

Date of Qualifying Event: \_\_/\_\_/\_\_\_\_

- ☐ New business enrollment    ☐ Open Enrollment event    ☐ Dependent birth or adoption    ☐ Loss of coverage  
☐ New hire / Newly eligible    ☐ Rehire / Reinstatement    ☐ Marital status change    ☐ Other \_\_\_\_\_

**Enrollment Information**

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs)	Gender	Full-time student?	Date of birth	Disabled? If yes, indicate reason and SSN within the field below.
Employee / Individual		/		<input type="radio"/> F <input type="radio"/> M	N/A	__/__/____	<input type="radio"/> N <input type="radio"/> Y Reason: SSN: N/A (complete in Employee / Individual Information section.)
Spouse / Domestic Partner		/		<input type="radio"/> F <input type="radio"/> M	N/A	__/__/____	<input type="radio"/> N <input type="radio"/> Y Reason: SSN:
Child / Dependent		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	__/__/____	<input type="radio"/> N <input type="radio"/> Y Reason: SSN:
Child / Dependent		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	__/__/____	<input type="radio"/> N <input type="radio"/> Y Reason: SSN:
Child / Dependent		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	__/__/____	<input type="radio"/> N <input type="radio"/> Y Reason: SSN:
Other (specify):		/		<input type="radio"/> F <input type="radio"/> M	<input type="radio"/> N <input type="radio"/> Y	__/__/____	<input type="radio"/> N <input type="radio"/> Y Reason: SSN:

[Within the past [1-12] months have you or, if applicable, your spouse, applying for coverage used any tobacco product?] ☐ N ☐ Y  
 [If yes, please indicate whether this answer applies to you (employee / individual) or your spouse] ☐ Employee / Individual ☐ Spouse

<b>Employee / Individual Information</b>	<b>[Hours worked per week:]</b>	<b>[Date of full time hire: __/__/____]</b>
SSN	Street address	APT / Suite / Box
City	State	ZIP code
Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other	E-mail address	Occupation
Employment status (check one) <input type="radio"/> Active <input type="radio"/> Retiree <input type="radio"/> COBRA	Annual salary \$	

**Prior / Existing Coverage: IMPORTANT - DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

<b>Medical</b>			
<b>[1-3]. [Prior medical coverage during the past [1-18] months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y]</b>			
[Prior medical insurance carrier name]	[Policy #]	<b>[Prior coverage type:]</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family	Effective date __/__/____ Term date __/__/____
<b>[1-3]. [Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y]</b>			
[Other medical insurance carrier name]	[Policy #]	<b>[Other coverage type:]</b> <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family	Effective date __/__/____ Term date __/__/____
<b>[1-3]. [Medicare]</b>			
[Employee / Individual coverage: <input type="radio"/> N <input type="radio"/> Y]	[Medicare ID]	Effective date __/__/____	Term date __/__/____
[Spouse coverage: <input type="radio"/> N <input type="radio"/> Y]	[Medicare ID]	Effective date __/__/____	Term date __/__/____

<b>Dental</b>			
[1-2]. [Prior dental coverage during the past [1-12] months (individual or other group coverage)? <input type="radio"/> N <input type="radio"/> Y]			
[1-2]. [Prior orthodontia coverage in the past [1-12] months? <input type="radio"/> N <input type="radio"/> Y]			
[Prior dental insurance carrier name]	Policy #	[Prior coverage type:] <input type="radio"/> [Employee / Individual only] <input type="radio"/> [Employee / Individual and spouse] <input type="radio"/> [Employee / Individual and child(ren)] <input type="radio"/> [Family]	
	Effective date __ / __ / ____		
[Prior carrier phone # ( )]	Term date __ / __ / ____		
<b>Coverage Options</b>			
<b>Medical</b>	Group #:	Benefit #:	Class/Div:
[Coverage type:] <input type="radio"/> Employee / Individual only <input type="radio"/> Employee / Individual and spouse <input type="radio"/> Employee / Individual and child(ren) <input type="radio"/> Family <input type="radio"/> No Coverage (complete waiver)]			[Plan name:]
<b>Health Savings Account</b>	Group #:	Benefit #:	Class/Div:
If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details. Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.			
[Do you elect the Health Savings Account? <input type="radio"/> N <input type="radio"/> Y (If no, complete waiver.)]	[Beneficiary for this account will be the employee / individual's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.]		
<b>Dental</b>	Group #:	Benefit #:	Class/Div:
[Coverage type:] <input type="radio"/> Employee / Individual only [Rate Amount \$ _____ Rate Frequency (Monthly)] <input type="radio"/> Employee / Individual and spouse [Rate Amount \$ _____ Rate Frequency (Monthly)] <input type="radio"/> Employee / Individual and child(ren) [Rate Amount \$ _____ Rate Frequency (Monthly)] <input type="radio"/> Family [Rate Amount \$ _____ Rate Frequency (Monthly)] <input type="radio"/> No Coverage (complete waiver)]			[Plan name:]
<b>Basic Life [/ AD&amp;D]</b>	Group #:	Benefit #:	Class/Div:
[Basic dependent life <input type="radio"/> N <input type="radio"/> Y (If no, complete waiver.)]		[Class (employer will provide you with this information, if needed)]	
<b>Voluntary Life [/ AD&amp;D]</b>	Group #:	Benefit #:	Class/Div:
[Voluntary employee / individual life coverage <input type="radio"/> N <input type="radio"/> Y]	[Amount (min \$1-unlimited)] \$]		
[Voluntary spouse life coverage? <input type="radio"/> N <input type="radio"/> Y]	[Amount (min \$1-unlimited)] \$]	[Voluntary child(ren) life coverage? <input type="radio"/> N <input type="radio"/> Y]	
<b>Vision</b>	Group #:	Benefit #:	Class/Div:
[Coverage type:] <input type="radio"/> Employee / Individual only [Rate Amount \$ _____ Rate Frequency (Monthly)] <input type="radio"/> Employee / Individual and spouse [Rate Amount \$ _____ Rate Frequency (Monthly)] <input type="radio"/> Employee / Individual and child(ren) [Rate Amount \$ _____ Rate Frequency (Monthly)] <input type="radio"/> Family [Rate Amount \$ _____ Rate Frequency (Monthly)] <input type="radio"/> No Coverage (complete waiver)]			[Plan name:]
<b>Short Term Disability</b>	Group #:	Benefit #:	Class: Div:
[Short Term Disability <input type="radio"/> N <input type="radio"/> Y (If no, complete waiver.)]		[Buy-up percent/amount _____]	
<b>Long Term Disability</b>	Group #:	Benefit #:	Class: Div:
[Long Term Disability <input type="radio"/> N <input type="radio"/> Y (If no, complete waiver.)]		[Buy-up percent/amount _____]	



**Workplace Voluntary Benefits: Optional riders availability based on employer / group election.**

<b>Accident</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="checkbox"/> Accident] <input type="checkbox"/> N <input type="checkbox"/> Y]		[Benefit Level:] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6]		
<b>[Coverage type:]</b> <input type="checkbox"/> Employee / Individual only] <input type="checkbox"/> Employee / Individual and spouse] <input type="checkbox"/> Employee / Individual and child(ren)] <input type="checkbox"/> Family]				
<input type="checkbox"/> Optional Hospital Intensive Care Unit Benefits Rider <input type="checkbox"/> \$1-50,000][per day] [per month] [per year] <input type="checkbox"/> \$1-50,000][per day] [per month] [per year] <input type="checkbox"/> \$1-50,000][per day] [per month] [per year] <input type="checkbox"/> \$1-50,000][per day] [per month] [per year]		<input type="checkbox"/> Optional Fracture and Dislocation Benefits Rider <input type="checkbox"/> \$1-50,000] <input type="checkbox"/> \$1-50,000]		
<input type="checkbox"/> Optional Accident Total Disability Benefits Rider: <b>Elimination Period:</b> <input type="checkbox"/> 1-120] [Month][Days][Year] <input type="checkbox"/> 1-120] [Month][Days][Year] <input type="checkbox"/> 1-120] [Month][Days][Year] <input type="checkbox"/> 1-120] [Month][Days][Year] <b>[Elimination Benefit:]</b> <input type="checkbox"/> \$1-50,000] <input type="checkbox"/> \$1-50,000] <input type="checkbox"/> \$1-50,000] <input type="checkbox"/> \$1-50,000] <input type="checkbox"/> \$1-50,000] <input type="checkbox"/> \$1-50,000] <input type="checkbox"/> \$1-50,000]				

<b>Accident 2012</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="checkbox"/> Accident] <input type="checkbox"/> N <input type="checkbox"/> Y]		[Benefit Level:] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6] <input type="checkbox"/> 1-6]		
<b>[Coverage type:]</b> <input type="checkbox"/> Employee / Individual only] <input type="checkbox"/> Employee / Individual and spouse] <input type="checkbox"/> Employee / Individual and child(ren)] <input type="checkbox"/> Family]				
<input type="checkbox"/> Pet Lodging] <input type="checkbox"/> \$1-1,000][per day] [per month] [per year] <input type="checkbox"/> \$1-1,000][per day] [per month] [per year] <input type="checkbox"/> \$1-1,000][per day] [per month] [per year] <input type="checkbox"/> \$1-1,000][per day] [per month] [per year]				

<b>Disability Income Plus</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="checkbox"/> Disability Income Covering Accident and Sickness] <input type="checkbox"/> N <input type="checkbox"/> Y] <b>[Base Benefit Period:]</b> <input type="checkbox"/> 1-120][Month][Days][Year] <input type="checkbox"/> 1-120][Days][Year] <input type="checkbox"/> 1-120] [Month][Days][Year] <input type="checkbox"/> 1-120][Month][Days][Year] <input type="checkbox"/> 1-120][Month][Days][Year] <b>[Base Elimination Period:]</b> <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500]				[Monthly Benefit \$]
<input type="checkbox"/> Disability Income Covering Accident and Sickness with Waiver of Elimination Period] <input type="checkbox"/> N <input type="checkbox"/> Y] <b>[Base Benefit Period:]</b> <input type="checkbox"/> 1-120][Month][Days][Year] <input type="checkbox"/> 1-120][Days][Year] <input type="checkbox"/> 1-120] [Month][Days][Year] <input type="checkbox"/> 1-120][Month][Days][Year] <input type="checkbox"/> 1-120][Month][Days][Year] <b>[Base Elimination Period:]</b> <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500]				
<b>[Optional Disability Income Benefits:]</b> <input type="checkbox"/> ICU / CCU Benefit] <input type="checkbox"/> \$1-2,000] <input type="checkbox"/> \$1-2,000] <input type="checkbox"/> \$1-2,000] <input type="checkbox"/> \$1-2,000] <input type="checkbox"/> \$1-2,000] <input type="checkbox"/> \$1-2,000] <input type="checkbox"/> Physical Therapy Benefit] <input type="checkbox"/> COBRA Rider] [COBRA Monthly Benefit \$]				

<b>Disability Income Advantage</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="checkbox"/> Disability Income Advantage] <input type="checkbox"/> N <input type="checkbox"/> Y] <b>[Base Benefit Period:]</b> <input type="checkbox"/> 1-120][Month][Days][Year] <input type="checkbox"/> 1-120][Days][Year] <input type="checkbox"/> 1-120] [Month][Days][Year] <input type="checkbox"/> 1-120][Month][Days][Year] <input type="checkbox"/> 1-120][Month][Days][Year] <b>[Base Elimination Period:]</b> <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500] <input type="checkbox"/> 0-500][ / 0-500]				[Monthly Benefit \$]
[Optional Riders:] <input type="checkbox"/> Hospital Confinement] <input type="checkbox"/> COBRA Rider]			[COBRA Monthly Benefit \$]	

<b>Whole Life [/ AD&amp;D]</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="checkbox"/> Whole Life] [/ AD&D] <input type="checkbox"/> N <input type="checkbox"/> Y]		<input type="checkbox"/> Whole Life 99]	<input type="checkbox"/> Whole Life 90]	<input type="checkbox"/> Whole Life 65]
[Employee / Individual Benefit \$]				
<input type="checkbox"/> AD&D Rider] <input type="checkbox"/> Automatic Premium Loan Option]				
<input type="checkbox"/> Automatic Benefit Increase Rider <input type="checkbox"/> \$1-120 / [Days][Week][Month] [Year] <input type="checkbox"/> \$1-120 / [Days][Week][Month] [Year]		<input type="checkbox"/> Employee / Individual Term Rider to 65 Employee / Individual Benefit \$]		<input type="checkbox"/> Family Term Rider Spouse Benefit [Child(ren) Benefit \$]

<b>Whole Life Spouse [/ AD&amp;D]</b>	<b>Group #:</b>	<b>Benefit #:</b>	<b>Class:</b>	<b>Div:</b>
<input type="checkbox"/> Stand Alone Spouse] [/ AD&D] <input type="checkbox"/> N <input type="checkbox"/> Y]		<input type="checkbox"/> Whole Life 99]	<input type="checkbox"/> Whole Life 90]	<input type="checkbox"/> Whole Life 65]
[Spouse Benefit \$]				
<input type="checkbox"/> AD&D Rider]		<input type="checkbox"/> Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount \$]		<input type="checkbox"/> Automatic Premium Loan Option]



<b>Whole Life Child(ren) [/ AD&amp;D]</b> Group #:		Benefit #:	Class:	Div:
[ <input type="radio"/> Whole Life Child(ren)] [/ AD&D] [ <input type="radio"/> N <input type="radio"/> Y ]				
<b>[Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.]</b>				
[ <input type="radio"/> N <input type="radio"/> Y <b>Coverage on Child 1</b>	Child 1 Name		Child 1 Benefit \$	
[ <input type="radio"/> N <input type="radio"/> Y <b>Coverage on Child 2</b>	Child 2 Name		Child 2 Benefit \$	
[ <input type="radio"/> N <input type="radio"/> Y <b>Coverage on Child 3</b>	Child 3 Name		Child 3 Benefit \$	
<b>Level Term Life</b> Group #:		Benefit #:	Class:	Div:
[ <input type="radio"/> Level Term Life] [/ AD&D] [ <input type="radio"/> N <input type="radio"/> Y ]		<b>[Coverage type:]</b> [ <input type="radio"/> Employee / Individual only] [ <input type="radio"/> Spouse] [ <input type="radio"/> Child(ren)] <b>[Base Plan:]</b> [ <input type="radio"/> 10-Year Term] [ <input type="radio"/> 20-Year Term] <b>[Optional Benefit:]</b> [ <input type="radio"/> Automatic Benefit Increase]		
[Employee / Individual Benefit \$]		[Spouse Benefit \$]	[Child(ren) Benefit \$]	
<b>[If your employer or group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100] ? <input type="radio"/> N <input type="radio"/> Y]</b> [If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent. <input type="radio"/> You (Employee / Individual)] [ <input type="radio"/> Spouse] [ <input type="radio"/> Dependent] [Name _____]]				
<b>Term to 95</b> Group #:		Benefit #:	Class:	Div:
[ <input type="radio"/> Term to 95] [ <input type="radio"/> N <input type="radio"/> Y ]		<b>[Coverage type:]</b> [ <input type="radio"/> Employee / Individual only] [ <input type="radio"/> Spouse] [ <input type="radio"/> Children]		
[Employee / Individual Benefit \$]		[Stand alone Spouse Benefit \$]	[Stand alone Child(ren) Benefit \$]	
<b>Critical Illness</b> Group #:		Benefit #:	Class:	Div:
<input type="radio"/> Critical Illness [ <input type="radio"/> N <input type="radio"/> Y ] <input type="radio"/> Critical Illness and Cancer [ <input type="radio"/> N <input type="radio"/> Y ]		<b>[Coverage type:]</b> [ <input type="radio"/> Employee / Individual only] [ <input type="radio"/> Employee / Individual and spouse] [ <input type="radio"/> Employee / Individual and child(ren)] [ <input type="radio"/> Family]		
<b>[Optional Benefits:]</b> [ <input type="radio"/> Automatic Benefit Increase] [ <input type="radio"/> Health Screening] [ <input type="radio"/> Return on Premium]			[Employee / Individual Benefit \$]	
<b>[Have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100]? <input type="radio"/> N <input type="radio"/> Y]</b> [If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent. <input type="radio"/> You (Employee / Individual)] [ <input type="radio"/> Spouse] [ <input type="radio"/> Dependent] [Name _____]]				
<b>Group Lump Sum Cancer</b> Group #:		Benefit #:	Class:	Div:
[ <input type="radio"/> Group Lump Sum Cancer] [ <input type="radio"/> N <input type="radio"/> Y ]		<b>[Coverage type:]</b> [ <input type="radio"/> Employee / Individual only] [ <input type="radio"/> Employee / Individual and spouse] [ <input type="radio"/> Employee / Individual and child(ren)] [ <input type="radio"/> Family]		
<b>[Have you or any dependent had a parent, brother, or sister with a history of cancer diagnosis prior to age [1-100] ? <input type="radio"/> N <input type="radio"/> Y]</b> [If yes, please indicate whether this applies to you (Employee / Individual), your spouse or a dependent. <input type="radio"/> You (Employee / Individual)] [ <input type="radio"/> Spouse] [ <input type="radio"/> Dependent] [Name _____]]				
<b>[Rider:]</b> [ <input type="radio"/> Automatic Benefit Increase] [ <input type="radio"/> Health Screenings]		[Base Benefit \$]		
<b>Cancer Lump Sum 10 - 50</b> Group #:		Benefit #:	Class:	Div:
[ <input type="radio"/> Cancer Lump Sum 10 - 50] [ <input type="radio"/> N <input type="radio"/> Y ]		<b>[Coverage type:]</b> [ <input type="radio"/> Employee / Individual only] [ <input type="radio"/> Employee / Individual and spouse] [ <input type="radio"/> Employee / Individual and child(ren)] [ <input type="radio"/> Family]		
<b>[Payment Period:]</b> [ <input type="radio"/> Lifetime] [ <input type="radio"/> 5-80 years] [ <input type="radio"/> 5-80 years][ <input type="radio"/> 5-80 years]		<b>[Rider:]</b> [ <input type="radio"/> Return on Premium]		[Base Benefit \$]
<b>Cancer Expense</b> Group #:		Benefit #:	Class:	Div:
[ <input type="radio"/> Cancer Expense] [ <input type="radio"/> N <input type="radio"/> Y ]		<b>[Coverage type:]</b> [ <input type="radio"/> Employee / Individual only] [ <input type="radio"/> Employee / Individual and spouse] [ <input type="radio"/> Employee / Individual and child(ren)] [ <input type="radio"/> Family]		
[ <input type="radio"/> Lump Sum Benefit (Equal to 50% of Base Benefit Amount)]		<b>[Rider:]</b> [ <input type="radio"/> Hospital Indemnity Rider]		[Base Benefit \$]
<b>Supplemental Health</b> Group #:		Benefit #:	Class:	Div:
[ <input type="radio"/> Supplemental Health] [ <input type="radio"/> N <input type="radio"/> Y ]		<b>[Coverage type:]</b> [ <input type="radio"/> Employee / Individual only] [ <input type="radio"/> Employee / Individual and spouse] [ <input type="radio"/> Employee / Individual and child(ren)] [ <input type="radio"/> Family]		
<b>[Plan type:]</b> [ <input type="radio"/> 1-6] [ <input type="radio"/> 1-6] [ <input type="radio"/> 1-6] [ <input type="radio"/> 1-6] [ <input type="radio"/> 1-6] [ <input type="radio"/> 1-6]				
<b>Beneficiary Information for Life, Disability and Workplace Voluntary Benefits</b>				
Primary beneficiary name (Last, First MI)			Relationship to Employee / Individual	
Secondary beneficiary name (Last, First MI)			Relationship to Employee / Individual	

## Evidence of Health Status

This information should not be submitted more than [1-60] days prior to the effective date. [Complete this section for individuals, including dependents, enrolling or applying for [medical,][disability,] [life,] [or] [workplace voluntary] benefit coverage.]

[This section is required to be filled out for [Group Term Life,] [Long Term Disability,] [and] [Short Term Disability], if the following criteria applies:]

[1-3.] [Over Guaranteed Issue Limit: Election of coverage exceeding the guaranteed issue amount (according to your policy) for which evidence of insurability is required.]

[1-3.] [Opting up to Higher Level of Coverage: election of additional increments of coverage with insurance currently in force.]

[1-3.] [Late Entrant: Employee who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force.]

[1-7.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	<input type="radio"/> N <input type="radio"/> Y]
[1-7.] [In the past [1-12] months, have you missed [1-5] or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu, [back problems,] strained/sprained/fractured/broken limb or as a result of pregnancy?	<input type="radio"/> N <input type="radio"/> Y]
[1-7.] [Have you or any dependent been diagnosed or received treatment for [an immune system disorder (i.e. Lupus, ITP),] AIDS or an AIDS-related complex?	<input type="radio"/> N <input type="radio"/> Y]
[1-7.] [Within the past [1-5] years, have you or any eligible dependent to be covered been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:]	

[a-o.] [Coronary artery disease, chest pain, heart surgery, or any disease of the arteries, or blood disorders; anemia; hemophilia; phlebitis; high blood pressure [(reading higher than 140/90)]?	<input type="radio"/> N <input type="radio"/> Y]	[a-o.] [Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	<input type="radio"/> N <input type="radio"/> Y]
[a-o.] [Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	<input type="radio"/> N <input type="radio"/> Y]	[a-o.] [Stomach, gall bladder, digestive, intestinal, or colon disorders?	<input type="radio"/> N <input type="radio"/> Y]
[a-o.] [Stroke; Transient Ischemic Attack (TIA)?	<input type="radio"/> N <input type="radio"/> Y]	[a-o.] [Rheumatoid arthritis [; [or] back disorders; or joint disorders]?	<input type="radio"/> N <input type="radio"/> Y]
[a-o.] [Emphysema; asthma, or other disease of lungs, or respiratory organs?	<input type="radio"/> N <input type="radio"/> Y]	[a-o.] [Paralysis, or any other physical impairment or deformity?	<input type="radio"/> N <input type="radio"/> Y]
[a-o.] [End stage renal disease; disease of kidney?	<input type="radio"/> N <input type="radio"/> Y]	[a-o.] [Chronic Fatigue Syndrome/Fibromyalgia?	<input type="radio"/> N <input type="radio"/> Y]
[a-o.] [Kidney stones; bladder?	<input type="radio"/> N <input type="radio"/> Y]	[a-o.] [Diseases of the eye, ear, nose, or throat?	<input type="radio"/> N <input type="radio"/> Y]
[a-o.] [Male or female organs; or infertility?	<input type="radio"/> N <input type="radio"/> Y]	[a-o.] [Alcoholism or drug habit?	<input type="radio"/> N <input type="radio"/> Y]
[a-o.] [Cancer, and/or cancerous tumor[; including skin cancer]?	<input type="radio"/> N <input type="radio"/> Y]		

[1-7.] [Has any Proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past [1-5] years?	<input type="radio"/> N <input type="radio"/> Y]
[1-7.] [Within the past [1-5] years, has anyone enrolling or applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	<input type="radio"/> N <input type="radio"/> Y]
[1-7.] [Are you or any dependent to be covered currently pregnant? If yes, please indicate anticipated delivery date below. [Anticipated delivery date: _____]	<input type="radio"/> N <input type="radio"/> Y]

[If you answered "yes" to any of the questions above, please provide details below and specify the question #. Attach additional signed and dated sheets, (reorder AR-51340-MH), if necessary.]

Question # & letter	Person treated (Last name, First name)	
Condition	Treatments received	
Medications prescribed	Current or future treatments or medications	
Date diagnosed __ / __ / ____	Date last seen by a doctor __ / __ / ____	

## Medical Health History

**This information should not be submitted more than 60 days prior to the effective date. [Complete this section for individuals, including dependents, enrolling for medical, disability, life, or workplace voluntary benefit coverage.]**

[1-6.] [Are you or any dependents to be covered currently pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:	<input type="radio"/> N <input type="radio"/> Y]
[1-6.] [In the past [1-12] months, have you missed [1-5] or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu [, back problems], strained/sprained/fractured/broken limb or as a result of pregnancy?	<input type="radio"/> N <input type="radio"/> Y]
[1-6.] [Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	<input type="radio"/> N <input type="radio"/> Y]
[1-6.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	<input type="radio"/> N <input type="radio"/> Y]
[1-6.] [During the last [1-24] months, have you or any dependents to be covered been diagnosed with, or treated for, any illness or injury or had surgery or hospitalization recommended?	<input type="radio"/> N <input type="radio"/> Y]
[1-6.] [Within the past [1-12] months, have you or any dependents to be covered incurred medical expenses in excess of [\$1-100,000]?	<input type="radio"/> N <input type="radio"/> Y]

**If selecting life, please complete the following questions:**

[1-4.] [In the past 5 years has any Proposed Insured been diagnosed, sought treatment, taken medication, or been hospitalized for any of the following: heart attack/heart surgery/heart disease, blood pressure readings above the normal range which have not been controlled with medication, stroke/transient ischemic attack (TIA), cancer (except basal cell skin cancer), end stage renal/kidney disease, diabetes (insulin dependent), alcohol and/or drug abuse, emphysema/lung disease, liver disease/hepatitis/cirrhosis, neurological disorder/multiple sclerosis, lupus, blood disorder, or epilepsy?	<input type="radio"/> N <input type="radio"/> Y]
[1-4.] [Had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age [1-100]?	<input type="radio"/> N <input type="radio"/> Y]
[1-4.] [Has any child proposed for coverage ever been diagnosed with or treated for congenital cardiac abnormality or other abnormalities, spina bifida, down's syndrome, cerebral palsy, or cystic fibrosis?	<input type="radio"/> N <input type="radio"/> Y]
[1-4.] [Has any Proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past [1-5] years?	<input type="radio"/> N <input type="radio"/> Y]

**[If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder AR-51340-MH), if necessary.]**

Question #	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed __ / __ / ____	Date last seen by a doctor __ / __ / ____

## Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

I hereby waive coverage for (check all that apply):

[Medical for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Dental for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Basic Life for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Vision for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Short Term Disability for:	<input type="radio"/> Myself]		
[Long Term Disability for:	<input type="radio"/> Myself]		
[Health Savings Account for:	<input type="radio"/> Myself]		

### Waive Coverage for Workplace Voluntary Benefits:

[Whole Life for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Level Term Life for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Term to 95 for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Critical Illness for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Group Lump Sum Cancer for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Cancer Lump Sum 10-50 for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Cancer Expense for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Supplemental Health for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Accident for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Disability Income Plus for:	<input type="radio"/> Myself]		
[Disability Income Advantage for:	<input type="radio"/> Myself]		

I decline to apply for group coverage because of:

☐ Spousal coverage]  
☐ Medicare supplement]  
☐ Individual coverage]  
☐ Coverage under another carrier's plan  
provided by my employer / group]  
☐ Other: \_\_\_\_\_]

## Agreement

### True and complete acknowledgement

I understand, agree, and represent:

- I have read the Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-31] days after the qualifying event.
- If I or my dependents become eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-60] days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future submissions of the Group Employee and Individual Application and Enrollment Form for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract or coverage within the contestable period, if such misrepresentation materially affected the acceptance of the risk.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Group Employee and Individual Application and Enrollment Form by Humana.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

## Authorization

### My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

### Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

**The Group Employee and Individual Application and Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for any policy or certificate.**

### Signature - please sign below if enrolling or waiving group coverage.

**If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.**

Employee / Individual or legal representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and relationship of legal representative: \_\_\_\_\_

Spouse signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Only if selecting Life coverage over the guarantee issue amount.)

## Agent / Producer Information

**If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.**

### 1. Agent / Agency of Record:

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split: \_\_\_\_\_

### 1. Writing Agent / Producer:

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split: \_\_\_\_\_

### 2. Agent / Agency of Record:

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split: \_\_\_\_\_

### 2. Writing Agent / Producer:

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split: \_\_\_\_\_

**Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)?** ☐ N ☐ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_

Writing Agent's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last name:

First name:

## Large Group Employee and Individual Application and Enrollment Form

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Large Group Employee and Individual Application and Enrollment Form as "Humana".

[[Medical] [and] [Life] plans [insured] [or] [administered] by [Humana Insurance Company].] [[Dental] plans [insured] [or] [administered] by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Dental HMO] plans offered by [American Dental Providers of Arkansas, Inc.]] [[Vision] plans [insured] [or] [administered] by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability], [Life] [and] [Workplace Voluntary] plans insured by [Kanawha Insurance Company].]

Print clearly and completely fill in each applicable circle.

Employer / Group name

Employer / Group city

State

### Qualifying Event Instructions

Office use only

☐ New business enrollment ☐ Open Enrollment event ☐ Marital status change ☐ Other \_\_\_\_\_

☐ New hire/Newly eligible ☐ Rehire/Reinstatement Qualifying event date (MM/DD/YYYY) Benefit effective date (MM/DD/YYYY)

☐ Dependent birth or adoption ☐ Loss of coverage  /  /   /  /

### Employee / Individual information

Last name

First name

MI

Social security number

Date of birth (MM/DD/YYYY)

Area code

Phone number

 -  -  /  /  (  )  - 

Height (ft / in)

Weight (lbs)

 / 

Street address

Apt / Suite / PO box number

Gender ☐ Female ☐ Male

Language of choice ☐ English ☐ Spanish

City

State

Zip code

County / Parish

E-mail address

Employment status ☐ Full-time employee / individual ☐ Retiree ☐ Cobra Date of full-time hire (MM/DD/YYYY)  /  /

Do you have a disability that affects your ability to communicate or read? ☐ No ☐ Yes

Are you disabled or unable to perform normal work activities?

☐ No ☐ Yes If yes, indicate reason: \_\_\_\_\_

Annual Salary

Hours Worked per Week

\$

Occupation

HMO/POOnly

Primary care physician name

Primary care physician ID #

Current patient?

☐ Yes ☐ No

HMO/POOnly

OBGYN Primary care physician name (if applicable)

Primary care physician ID #

Current patient?

☐ Yes ☐ No

Last name:

First name:

**Dependent information**

Enter information for each covered dependent, including spouse.

**1** Dependent last name  First name  MI  Gender ☐ Female ☐ Male

Social security number  -  -  Date of birth (MM/DD/YYYY)  /  /  Relationship ☐ Spouse ☐ Child ☐ Other: \_\_\_\_\_

Height (ft / in)  /  Weight (lbs)  /  Dependent status (if applicable): ☐ Full-time student ☐ Disabled  
If disabled, indicate reason: \_\_\_\_\_

**Not applicable for HumanaAccess HMO**

HMO/POS only Primary care physician name  Primary care physician ID #  Current patient? ☐ Yes ☐ No

HMO/POS only OBGYN Primary care physician name (if applicable)  Primary care physician ID #  Current patient? ☐ Yes ☐ No

**2** Dependent last name  First name  MI  Gender ☐ Female ☐ Male

Social security number  -  -  Date of birth (MM/DD/YYYY)  /  /  Relationship ☐ Spouse ☐ Child ☐ Other: \_\_\_\_\_

Height (ft / in)  /  Weight (lbs)  /  Dependent status (if applicable): ☐ Full-time student ☐ Disabled  
If disabled, indicate reason: \_\_\_\_\_

**Not applicable for HumanaAccess HMO**

HMO/POS only Primary care physician name  Primary care physician ID #  Current patient? ☐ Yes ☐ No

HMO/POS only OBGYN Primary care physician name (if applicable)  Primary care physician ID #  Current patient? ☐ Yes ☐ No

**3** Dependent last name  First name  MI  Gender ☐ Female ☐ Male

Social security number  -  -  Date of birth (MM/DD/YYYY)  /  /  Relationship ☐ Spouse ☐ Child ☐ Other: \_\_\_\_\_

Height (ft / in)  /  Weight (lbs)  /  Dependent status (if applicable): ☐ Full-time student ☐ Disabled  
If disabled, indicate reason: \_\_\_\_\_

**Not applicable for HumanaAccess HMO**

HMO/POS only Primary care physician name  Primary care physician ID #  Current patient? ☐ Yes ☐ No

HMO/POS only OBGYN Primary care physician name (if applicable)  Primary care physician ID #  Current patient? ☐ Yes ☐ No

**4** Dependent last name  First name  MI  Gender ☐ Female ☐ Male

Social security number  -  -  Date of birth (MM/DD/YYYY)  /  /  Relationship ☐ Spouse ☐ Child ☐ Other: \_\_\_\_\_

Height (ft / in)  /  Weight (lbs)  /  Dependent status (if applicable): ☐ Full-time student ☐ Disabled  
If disabled, indicate reason: \_\_\_\_\_

**Not applicable for HumanaAccess HMO**

HMO/POS only Primary care physician name  Primary care physician ID #  Current patient? ☐ Yes ☐ No

HMO/POS only OBGYN Primary care physician name (if applicable)  Primary care physician ID #  Current patient? ☐ Yes ☐ No









Last name:

First name:

**Voluntary Life [/ AD&D]****Office use only**

Group #

Benefit #

Class/Div #

[Do you elect voluntary employee / individual life coverage?

☐ Yes ☐ No [If no, complete waiver section]][If yes, amount elected (minimum of [\$1-Unlimited:])] \$  ,  .00]**Voluntary dependent life selection (available only if employee / individual elects voluntary life coverage):**[Do you elect voluntary spouse life coverage? ☐ Yes ☐ No If no, complete waiver section][If yes, voluntary spouse life coverage (minimum of [\$1-Unlimited:]): \$  ,  .00][Do you elect voluntary child(ren) life coverage? ☐ Yes ☐ No If no, complete waiver section]**Vision****Office use only**

Group #

Benefit #

Class/Div #

[Covered individual]

☐ Employee / Individual only]☐ Employee / Individual and spouse]☐ Employee / Individual and child(ren)]☐ Family]☐ Other]

Plan name

**Short Term Disability**

[Do you elect short term disability coverage?

☐ Yes ☐ No If no, complete waiver section]

[Buy-up percent/amount \_\_\_\_\_]

**Office use only**

Group #

Benefit #

Class #

Div #

**Long Term Disability**

[Do you elect long term disability coverage?

☐ Yes ☐ No If no, complete waiver section]

[Buy-up percent/amount \_\_\_\_\_]

**Office use only**

Group #

Benefit #

Class #

Div #

**Group Term Life [/ AD&D]****Office use only**

Group#

Benefit#

Class#

Div#

Coverage requested for (check all that apply)

[Employee / Individual]

☐ Basic Term Life☐ Supplemental Term Life\*☐ Basic AD&D☐ Supplemental AD&D

[Spouse]

☐ Basic Term Life☐ Supplemental Term Life\*☐ Basic AD&D☐ Supplemental AD&D

[Child(ren)]

☐ Basic Term Life☐ Supplemental Term Life\*☐ Basic AD&D☐ Supplemental AD&DCoverage requested  
(complete only if plan provides a choice of benefit schedules)

Cost per pay period

\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]\$  ,  .00]

\*Complete Evidence of Insurability form if selecting one of these benefit amounts.

Last name:

First name:

**Workplace Voluntary Benefits: Optional riders availability based on employer / group election.****Accident**Office use only Group #         Benefit #         Class #    Div #    ☐ Accident] ☐ N ☐ Y] **[Benefit Level:]** ☐ 1-6] ☐ 1-6] ☐ 1-6] ☐ 1-6] ☐ 1-6] ☐ 1-6]**Coverage type:]** ☐ Employee / Individual only] ☐ Employee / Individual and spouse] ☐ Employee / Individual and child(ren)]  
☐ Family]☐ Optional Hospital Intensive Care Unit Benefits Rider] ☐ \$ 1-50,000] [per day][per month][per year]☐ \$ 1-50,000] [per day][per month][per year]☐ \$ 1-50,000] [per day][per month][per year]☐ \$ 1-50,000] [per day][per month][per year]☐ Optional Fracture and Dislocation Benefits Rider] ☐ \$ 1-50,000] ☐ \$ 1-50,000]☐ Optional Accident Total Disability Benefits Rider: Elimination Period] ☐ 1-120] [Month][Days][Year] ☐ 1-120] [Month][Days][Year]☐ 1-120] [Month][Days][Year] ☐ 1-120] [Month][Days][Year][Elimination Benefit] ☐ \$ 1-50,000] ☐ \$ 1-50,000] ☐ \$ 1-50,000] ☐ \$ 1-50,000]☐ \$ 1-50,000] ☐ \$ 1-50,000] ☐ \$ 1-50,000]**Accident 2012**Office use only Group #         Benefit #         Class #    Div #    ☐ Accident] ☐ N ☐ Y] **[Benefit Level:]** ☐ 1-6] ☐ 1-6] ☐ 1-6] ☐ 1-6] ☐ 1-6] ☐ 1-6] ☐ 1-6]**[Coverage type:]** ☐ Employee / Individual only] ☐ Employee / Individual and spouse] ☐ Employee / Individual and child(ren)]  
☐ Family]☐ Pet Lodging] ☐ \$ 1-1,000] [per day][per month][per year] ☐ \$ 1-1,000] [per day][per month][per year]☐ \$ 1-1,000] [per day][per month][per year] ☐ \$ 1-1,000] [per day][per month][per year]**Disability Income Plus**Office use only Group #         Benefit #         Class #    Div #    ☐ Disability Income Covering Accident and Sickness] ☐ N ☐ Y]**[Base Benefit Period:]** ☐ 1-120] [Month][Days][Year] ☐ 1-120] [Month][Days][Year] ☐ 1-120] [Month][Days][Year]☐ 1-120] [Month][Days][Year] ☐ 1-120] [Month][Days][Year]**[Base Elimination Period:]** ☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500]☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500]☐ Disability Income Covering Accident and Sickness with Waiver of Elimination Period] ☐ N ☐ Y]**[Base Benefit Period:]** ☐ 1-120] [Month][Days][Year] ☐ 1-120] [Days][Year]☐ 1-120] [Month][Days][Year]☐ 1-120] [Month][Days][Year]☐ 1-120] [Month][Days][Year]**[Base Elimination Period:]** ☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500]☐ 0-500] [/ 0-500] ☐ 0-500] [/ 0-500]**[Optional Disability Income Benefits:]** ☐ ICU/CCU Benefit] ☐ \$ 1-2,000]☐ \$ 1-2,000] ☐ \$ 1-2,000] ☐ \$ 1-2,000] ☐ \$ 1-2,000]☐ Physical Therapy Benefit]☐ COBRA Rider][Monthly Benefit  
\$    ,    .00]

[COBRA Monthly Benefit

\$    ,    .00]

Last name:

First name:

**Disability Income Advantage**Office use only Group #         Benefit #         Class #    Div #    ☐ Disability Income Advantage ☐ N ☐ Y[Base Benefit Period:] ☐ 1-120 [Month][Days][Year] ☐ 1-120 [Month][Days][Year] ☐ 1-120 [Month][Days][Year] ☐ 1-120 [Month][Days][Year][Monthly Benefit]  
\$    ,    .00[Base Elimination Period:] ☐ 0-500[/ 0-500] ☐ 0-500[/ 0-500] ☐ 0-500[/ 0-500] ☐ 0-500[/ 0-500] ☐ 0-500[/ 0-500] ☐ 0-500[/ 0-500][COBRA Monthly Benefit]  
\$    ,    .00[Optional Riders:] ☐ Hospital Confinement ☐ COBRA Rider**Whole Life [/ AD&D]**Office use only Group #         Benefit #         Class #    Div #    ☐ Whole Life [/ AD&D] ☐ N ☐ Y ☐ Whole Life 99 ☐ Whole Life 90 ☐ Whole Life 65

[Employee / Individual Benefit]

☐ AD&D Rider ☐ Automatic Premium Loan Option\$    ,    .00☐ Automatic Benefit Increase Rider☐ Employee Term Rider to 65☐ Family Term Rider☐ \$ 1-120 / [Days][Week][Month][Year]

Employee / Individual Benefit

Spouse Benefit \$ \_\_\_\_\_

☐ \$ 1-120 / [Days][Week][Month][Year]

\$ \_\_\_\_\_

Child(ren) Benefit \$ \_\_\_\_\_

**Whole Life Spouse [/ AD&D]**Office use only Group #         Benefit #         Class #    Div #    ☐ Whole Life Spouse [/ AD&D] ☐ N ☐ Y ☐ Whole Life 99 ☐ Whole Life 90 ☐ Whole Life 65

[Spouse Benefit]

☐ AD&D Rider ☐ Automatic Premium Loan Option\$    ,    .00☐ Family Term Rider (Child Coverage Only) Child(ren) Benefit Amount \$ \_\_\_\_\_**Whole Life Child(ren) [/ AD&D]**Office use only Group #         Benefit #         Class #    Div #    ☐ Whole Life Child(ren) [/ AD&D] ☐ N ☐ Y

[Child(ren) listed here must also be included as dependents under the Enrollment Information section of this application.]

☐ N ☐ Y **Coverage on Child 1** Child 1 Name \_\_\_\_\_ Child 1 Benefit \$ \_\_\_\_\_☐ N ☐ Y **Coverage on Child 2** Child 2 Name \_\_\_\_\_ Child 2 Benefit \$ \_\_\_\_\_☐ N ☐ Y **Coverage on Child 3** Child 3 Name \_\_\_\_\_ Child 3 Benefit \$ \_\_\_\_\_**Level Term Life**Office use only Group #         Benefit #         Class #    Div #    ☐ Level Term Life ☐ N ☐ Y **[Coverage type:]** ☐ Employee / Individual only ☐ Spouse ☐ Child(ren) ☐ No Coverage**[Base Plan:]** ☐ 10 Year Term ☐ 20 Year Term**[Optional Benefit:]** ☐ Automatic Benefit Increase

[Employee / Individual Benefit]

[Spouse Benefit]

[Child(ren) Benefit]

\$    ,    .00 \$    ,    .00 \$    ,    .00**[If your employer or group has elected the critical illness rider, have you or any dependent had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 1-100]? ☐ N ☐ Y ]**

[If yes, please indicate whether this applies to you (employee / individual), your spouse or a dependent.]

☐ You (employee / individual) ☐ Spouse ☐ Dependent [Name \_\_\_\_\_]**Term to 95**Office use only Group #         Benefit #         Class #    Div #    ☐ Term to 95 ☐ N ☐ Y **[Coverage type:]** ☐ Employee / Individual only ☐ Spouse ☐ Children ☐ No Coverage

[Employee / Individual Benefit]

[Stand alone Spouse Benefit]

[Stand alone Child(ren) Benefit]

\$    ,    .00 \$    ,    .00 \$    ,    .00

First name:

<b>Office use only</b>	Group #	Benefit #	Class #	Div #
<input type="checkbox"/> Critical Illness <input type="checkbox"/> Critical Illness and Cancer	<input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y	<b>Coverage type:</b> <input type="checkbox"/> Employee / Individual only <input type="checkbox"/> Employee / Individual and child(ren)	<input type="checkbox"/> Employee / Individual and spouse <input type="checkbox"/> Family	
<b>[Optional Benefits:]</b> <input type="checkbox"/> Automatic Benefit Increase <input type="checkbox"/> Health Screening <input type="checkbox"/> Return on Premium			[Employee / Individual Benefit \$ _____ , _____ .00]	

Last name:

First name:

**Evidence of Health Status**

This information should not be submitted more than [1-60] days prior to the effective date. [Complete this section for individuals, including dependents, enrolling or applying for [disability,] [life] [or] [workplace voluntary benefit] coverage.]

[[Long Term Disability] [and] [Short Term Disability] if the following criteria applies:]

[1-3.] [Over Guaranteed Issue Limit: Election of coverage exceeding the guaranteed issue amount (according to your policy) for which evidence of insurability is required.]

[1-3.] [Opting up to Higher Level of Coverage: election of additional increments of coverage with insurance currently in force.]

[1-3.] [Late Entrant: Employee who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force.]

[1-8.] [Within the past [1-12] months have you or, if applicable, your spouse, applying for coverage used any tobacco product? If yes, please indicate whether this answer applies to you (employee /individual) or your spouse <input type="radio"/> Employee / Individual <input type="radio"/> Spouse	<input type="radio"/> N <input type="radio"/> Y
[1-8.] [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	<input type="radio"/> N <input type="radio"/> Y
[1-8.] [In the past [1-12]months, have you missed [1-5] or more consecutive days of work due to an injury or illness other than as a result of a cold, the flu[, back problems], strained/sprained/fractured/broken limb or as a result of pregnancy?	<input type="radio"/> N <input type="radio"/> Y
[1-8.] [Have you or any dependent been diagnosed or received treatment for [an immune system disorder (i.e. Lupus, ITP),] AIDS or an AIDS-related complex?	<input type="radio"/> N <input type="radio"/> Y
[1-8.] [Within the past [1-5] years, have you or any eligible dependent to be covered been diagnosed with diseases or disorders related to, counseled, consulted, or treated by a doctor, including surgery, for any of the following:]	

[a-o.] Coronary artery disease, chest pain, heart surgery, or any disease of the arteries or blood disorders; anemia; hemophilia; phlebitis; high blood pressure [(reading higher than 140/90 or above)]?	<input type="radio"/> N <input type="radio"/> Y	[a-o.] Diabetes; liver or thyroid disease; hepatitis; cirrhosis; or enlargement of the lymph nodes?	<input type="radio"/> N <input type="radio"/> Y
[a-o.] Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness; Multiple Sclerosis; Parkinson's Disease; Cerebral Palsy?	<input type="radio"/> N <input type="radio"/> Y	[a-o.] Stomach, gall bladder, digestive, intestinal or colon disorders?	<input type="radio"/> N <input type="radio"/> Y
[a-o.] Stroke; Transient Ischemic Attack (TIA)?	<input type="radio"/> N <input type="radio"/> Y	[a-o.] Rheumatoid arthritis[; [or] back disorders; or joint disorders]?	<input type="radio"/> N <input type="radio"/> Y
[a-o.] Emphysema; asthma or other disease of lungs or respiratory organs?	<input type="radio"/> N <input type="radio"/> Y	[a-o.] Paralysis, or any other physical impairment or deformity?	<input type="radio"/> N <input type="radio"/> Y
[a-o.] End stage renal disease; disease of kidney?	<input type="radio"/> N <input type="radio"/> Y	[a-o.] Chronic Fatigue Syndrome/Fibromyalgia?	<input type="radio"/> N <input type="radio"/> Y
[a-o.] Kidney stones; bladder?	<input type="radio"/> N <input type="radio"/> Y	[a-o.] Diseases of the eye, ear, nose or throat?	<input type="radio"/> N <input type="radio"/> Y
[a-o.] Male or female organs; or infertility?	<input type="radio"/> N <input type="radio"/> Y	[a-o.] Alcoholism or drug habit?	<input type="radio"/> N <input type="radio"/> Y
[a-o.] Cancer, and/or cancerous tumor[; including skin cancer]? (state type & part of body in details section below)	<input type="radio"/> N <input type="radio"/> Y		

[1-8.] [Has any proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past [1-5] years?	<input type="radio"/> N <input type="radio"/> Y
[1-8.] [Within the past [1-5] years, has anyone enrolling or applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?	<input type="radio"/> N <input type="radio"/> Y
[1-8.] [Are you or any dependent to be covered pregnant? If yes, please indicate anticipated delivery date below. [Anticipated delivery date: _____]	<input type="radio"/> N <input type="radio"/> Y

If you answered "yes" to any of the questions above, please provide details below and specify the question #.

Attach additional signed and dated sheets (reorder AR-51340-MH) if necessary.

Question # & Letter	(Person Treated) Last name	First name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Condition	Treatments received		
<input type="text"/>	<input type="text"/>		
Medications prescribed	Current or future treatments or medications		
<input type="text"/>	<input type="text"/>		
Date diagnosed (MM/DD/YYYY)	Date last seen by a doctor (MM/DD/YYYY)		
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>		

### Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I hereby waive coverage for (check all that apply):

[Medical for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Dental for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Basic Life for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Voluntary Life for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Vision for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Group Term Life for:	<input type="radio"/> Myself]		
[Short Term Disability for:	<input type="radio"/> Myself]		
[Long Term Disability for:	<input type="radio"/> Myself]		
[Health Savings Account for:	<input type="radio"/> Myself]		
[Flexible Health Account for:	<input type="radio"/> Myself]		
[Flexible Dependent Care Account for:	<input type="radio"/> Myself]		

#### Waive Coverage for Workplace Voluntary Benefits:

[Whole Life for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Level Term Life for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Term to 95 for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Critical Illness Expense for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Group Lump Sum Cancer for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Cancer Lump Sum 10-50 for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Cancer Expense for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Supplemental Health for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Accident for:	<input type="radio"/> Myself	<input type="radio"/> My spouse	<input type="radio"/> My dependent child(ren)]
[Disability Income Plus for:	<input type="radio"/> Myself]		
[Disability Income Advantage for:	<input type="radio"/> Myself]		

I decline to apply for group coverage because of:

☐ Spousal coverage]  
☐ Medicare supplement]  
☐ Individual coverage]  
☐ Coverage under another carrier's plan provided by my employer / group]  
☐ Other:

### True and complete acknowledgement

I understand, agree, and represent:

- I have read the Large Group Employee and Individual Application and Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If the Large Group Employee and Individual Application and Enrollment Form for coverage is accepted, coverage will be effective on the date specified by Humana on the policy or certificate of insurance.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-31] days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent Large Group Employee and Individual Application and Enrollment Form shall be subject to the applicable terms and conditions of the master group contract(s), policy provisions or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- If I or my dependents becomes eligible for premium or rate subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that

I request enrollment within 60 days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to an HDHP.

- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer / group for the purposes of depositing any contributions.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Large Group Employee and Individual Application and Enrollment Form.
- If I have selected workplace voluntary benefits, and if coverage is not issued as initially applied for, I hereby authorize Humana to decrease or increase the premium or rate amount stated on the Large Group Employee and Individual Application and Enrollment Form to cover the benefit actually issued.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny claims or void the contract or coverage within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Large Group Employee and Individual Application and Enrollment Form by Humana.



Last name:

First name:

## Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with this Large Group Employee and Individual Application and Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

### Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

**The Large Group Employee and Individual Application and Enrollment Form, together with any supplements, will form part of any contract and be the basis for any policy or certificate**

## Signature - Please sign below if enrolling or waiving any group coverage

Employee / Individual or legal  
representative signature

Date   /   /

Name and relationship of legal representative \_\_\_\_\_

(if a covered dependent)

## Agent / Producer Information

**If applying for workplace voluntary benefits, this section to be completed by Agent or Producer.**

### 1. Agent / Agency of Record:

Name (print)

Humana Agent #

Commission split:

### 2. Agent / Agency of Record:

Name (print)

Humana Agent #

Commission split:

### 1. Writing Agent / Producer:

Name (print)

Humana Agent #

Commission split:

### 2. Writing Agent / Producer:

Name (print)

Humana Agent #

Commission split:

**Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)?** ☐ N ☐ Y

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Large Group Employee and Individual Application and Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_

Writing Agent's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



SERFF Tracking Number:	HUMA-127883199	State:	Arkansas
Filing Company:	Humana Dental Insurance Company	State Tracking Number:	50496
Company Tracking Number:	AR-11-009		
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	AR App Maint - HDIC		
Project Name/Number:	Apps Update/PC-114		

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved	12/20/2011
<b>Comments:</b>	see attached		
<b>Attachment:</b>	Catron-Certificate of Readability - AR-11-009.pdf		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Bypassed - Item:</b>	Application	Approved	12/20/2011
<b>Bypass Reason:</b>	n/a		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Statement of Variability	Approved	12/20/2011
<b>Comments:</b>	see attached		
<b>Attachment:</b>	Statement of Variability.Application.pdf		

**HUMANA DENTAL INSURANCE COMPANY**

***CERTIFICATE OF READABILITY***

**Filing # AR-11-009**

I hereby certify that these forms exceed the minimum reading ease score of 40 required by the State of Arkansas.

A handwritten signature in black ink, appearing to read "J. Gregory Catron", is positioned above a horizontal line.

---

J. Gregory Catron  
Vice President  
Humana Dental Insurance Company

## **Statement of Variability for Application Forms**

### **Bracketed Sections**

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, payment information, or agreements.
2. Bracketed sections are identified by green brackets.

**NOTE:** Some exceptions will apply due to state requirements or rulings regarding bracketing.

3. Non-bracketed logos, text, or numbers within the section remains constant and will not be subject to changes without being refiled.
4. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.
  - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.
5. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

### **Bracketed Numbers**

1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.
  - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.
  - Reorder numbers (Group forms) and Revision numbers (Individual forms) are located in the lower right-hand corner of the form and are considered variable and included within this statement.
2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.
3. Bracketed numbers will include the minimum and maximum ranges.
4. If the state determines ranges are not acceptable, only a single number will be shown on the form and that number will not be bracketed.

## **Bracketed Questions**

1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).
2. Any bracketed variables within that question are subject to change.
3. Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

## **Instructions or Help Text**

1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.
2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

## **Product Information**

1. Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements
2. Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
  - prior approval of certificate or policy forms for the new products or benefits; and,
  - any statutory or regulatory requirements

## **Legal Entities**

1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.
2. Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's/groups selection.
3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

## **Demographic Information**

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

## **Administrative Changes and Clerical Errors**

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.